

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 23 Film 110
3/11/69 kk

03995

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03988

1. DECEASED-NAME (Type or Print) HARRY JOHN ABEL			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year Mar 5 89			2b. HOUR 3:25 PM
3. SEX Male	4. RACE white	5. DATE OF BIRTH April 25, 1896	6. AGE (in years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS 10 10	IF UNDER 24 HRS. HOURS MIN 10 10	2c. DATE PRONOUNCED DEAD Month Day Year March 5, 1969 19
7a. BIRTHPLACE (State or foreign country) New York City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 14000 Castle Blvd		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Pressman		12b. KIND OF BUSINESS OR INDUSTRY Gv't Print Off.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME Henry		15. MOTHER'S MAIDEN NAME Mary		13e. STREET AND NUMBER 14000 Castle Blvd. Apt. 802		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW1 Navy		16b. SOCIAL SECURITY NO. 1041 Navy		17. INFORMANT wife		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolus, bilateral, 812.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to auto accident DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 8:55 HOUR A.M. 2-25 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) Deceased, driving alone in auto which another car struck		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No. City or Town County State Greentree Rd. Bethesda Montgomery Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE Belden R. Reap		M.D.		22b. DATE SIGNED March 5, 1969		
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		ADDRESS 17557-Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR MAR 6 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-8-69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.
24. FUNERAL DIRECTOR Robert A. Pumphrey				25b. REGISTRAR'S SIGNATURE Charles Judge		

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[illegible]

XTC/E

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>039989</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 6 Film 6411 4/11/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>03989</div>																	
1. DECEASED-NAME (Type or print)			First GUNTHER			Middle S			Last ADAMS			2a. DATE OF DEATH Month Day Year Mar 31 - 69			2b. HOUR 12:00 AM		
3. SEX MALE			4. RACE White			5. DATE OF BIRTH Feb. 18, 1896			6. AGE (In years last birthday) 73 1/2 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.								
10. CITY OR TOWN OF DEATH S.I. SP6. MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SYLVAN HICK HEALTH CARE CENTER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY PLASTERER								
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE MD.			13b. COUNTY BALT.			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 3203 N. Charles ST.					
14. FATHER'S NAME First KARL			Middle ADAMS			Last HARRIET W. Beckwith			15. MOTHER'S MAIDEN NAME First HARRIET W. Beckwith			Middle BALT. MD.			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) Yes WW I.			16b. SOCIAL SECURITY NO 215-16-1530			17. INFORMANT Georgette Hobarce - 232 KENDRICK AVE.			Address BALT. MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion</u> 1420 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Rt. Parotid</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from Oct 4, 1968, to Mar 31, 1969, that (I) (we) lost saw the deceased alive on Mar 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Robert L. Thibodeau						DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-31-69							
22d. PHYSICIAN'S NAME (Type) DR. R. THIBODEAU						22e. ADDRESS Rockville 20852											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-2-1969		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				23d. LOCATION (City or Town) Parkville		(County) Balto.		(State) Md					
24. FUNERAL DIRECTOR LASSA HNN Fun Home - BALT MD.						ADDRESS BLAIR RD		25a. REC'D BY REGISTRAR APR 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge							

MADE IN U.S.A.

NO. 100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
45M - 1/69

03997

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03990

1. DECEASED-NAME (Type or print) First Middle Last <i>Vincent Edmond Adams</i>			2a. DATE OF DEATH Month Day Year <i>3 24 69</i>			2b. HOUR <i>7:20</i> M					
3. SEX <i>MALE</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH <i>4-18-05</i>		6. AGE (In years last birthday) <i>63</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			Md.		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington San + Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Printer</i>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>7810 Garland Ave</i>			
14. FATHER'S NAME First Middle Last <i>Fred Adams</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mattie Wheeler</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>Chart</i> Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>7123</i> IMMEDIATE CAUSE (a) <i>meningitis, acute.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia + osteoarthritis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe Osteoporosis 2nd spinal + Rheumatoid Arthritis.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>2-17</i> , 19 <i>69</i> , to <i>3-23</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3-23</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>George M. Crames M.D.</i> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <i>George M. Crames</i>					22e. ADDRESS <i>7400 Carroll Ave., Takoma Park, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>March 27-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rockwood Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Sherrington Heights - Md</i>					
24. FUNERAL DIRECTOR <i>Arthur Walters</i> ADDRESS <i>254 Carroll St. 7.</i>					25. REC'D BY REGISTRAR DATE <i>MAR 27 1969</i>		26. REGISTRAR'S SIGNATURE <i>Richard Jones</i>				

11-25-60

68250

STANDARD INDUSTRIAL

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) JACQUELINE M ADDISON			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3 26 69			2b. HOUR 12:30				
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH 11/18/68	6. AGE (in years last birthday) 4 YRS	IF UNDER 1 YEAR MONTHS 4 DAYS	IF UNDER 24 HRS HOURS 4 MIN	2c. DATE PRONOUNCED DEAD Month 3 Day 26 Year 69			2d. HOUR 12:30	
7a. BIRTHPLACE (State or foreign country) Bethesda Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) minor			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Rockville Md			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Larry Middle A Last Addison			15. MOTHER'S MAIDEN NAME First Delorse Middle V. Last Watson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none				
16b. SOCIAL SECURITY NO.			17. INFORMANT father Larry 102 Dawson Ave. Rockville Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 746.0 Congenital heart disease manifest DUE TO, OR AS A CONSEQUENCE OF (b) by left lower pulmonary artery DUE TO, OR AS A CONSEQUENCE OF (c) communication with left atrium										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Belden R. Reap			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 3/26/1969				
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL			23b. DATE 3-29-69			23c. NAME OF CEMETERY OR CREMATORY Ash Memorial			23d. LOCATION (City or Town) (County) (State) Sandy Spring Montg Md	
24. FUNERAL DIRECTOR Robert L. Snowden			ADDRESS Rockville Md			25a. REC'D BY REGISTRAR APR 3 1969			25b. REGISTRAR'S SIGNATURE Charles Judge	

10-11-54

05938

RECEIVED BY THE DIRECTOR OF THE FBI

WASHINGTON, D. C.

10-11-54

TO DIRECTOR

FROM

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03999										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03992																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last LEIGH C. ALLNUTT										Month Day Year MARCH 1 1969										M																													
3. SEX F										4. RACE W										5. DATE OF BIRTH 9-16-1882										6. AGE (In years last birthday) 86 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) N.Y.										7b. CITIZEN OF WHAT COUNTRY? U.S.										B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH MONTGOMERY																			
10. CITY OR TOWN OF DEATH SILVER SPRING										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SILVER MANOR HEALTH CARE CENTER										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD 8805 WALNUT HILL RD.										13b. CITY OR TOWN MONTGOMERY GAITHERSBURG										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 8805 WALNUT HILL RD.																			
14. FATHER'S NAME First Middle Last G. W. CHATE.										15. MOTHER'S MAIDEN NAME First Middle Last Annie W. Finley																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO										16b. SOCIAL SECURITY NO. 213-504-146										17. INFORMANT MRS. T. S. MASON, JR.										Address 8805 WALNUT HILL RD. GAITHERSBURG, MD.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DIS. DUE TO, OR AS A CONSEQUENCE OF (c)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
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22a. I certify that (I) (this hospital) attended the deceased from FEB 7, 1969, to MARCH 1, 1969, that (I) (we) lost saw the deceased alive on FEB 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE Robert T. Thibadeau										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED MAR 1-69																													
22d. PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU										22e. ADDRESS ROCKVILLE MD 20852																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 3/4/69										23c. NAME OF CEMETERY OR CREMATORY Rockville										23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery, Md.																			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home										Rockville, Md.										FILED BY REGISTRAR MAR 4 1969										25b. REGISTRAR'S SIGNATURE [Signature]																			

[Faint, mostly illegible text across the page, possibly bleed-through from the reverse side. Some words like "The", "and", "of" are visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

04000

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03993

1. DECEASED-NAME (Type or Print) <i>Gilford</i> First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year <i>March 15 1969</i>			2b. HOUR <i>6:30</i>					
3 SEX <i>male</i>		4. RACE <i>white</i>		5 DATE OF BIRTH <i>9/27/14</i>		6 AGE (in years last birthday) <i>54</i> YRS		7c. DATE PRONOUNCED DEAD Month Day Year <i>March 15 1969</i>		2d. HOUR <i>6:30</i>	
7a. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR IND. STRY <i>Gen'l Mgr. I.C.O.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Mont. Prince Georges</i>			13c. CITY OR TOWN <i>Washington</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>5304 Westport Rd.</i>											
14. FATHER'S NAME First Middle Last <i>Henry Amick</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Edell</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO <i>236-05-4445</i>			17. INFORMANT <i>Ruby Amick</i>			ADDRESS <i>1500...</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> <i>410.1</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>old myocardial Infarct</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year Hour A.M. P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John G. Ball</i>			EXAMINER'S NAME (Type) <i>JOHN G. BALL, M.D.</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED <i>March 16, 1969</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE <i>MARCH 18, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State) <i>RAINELLE, WEST VIRGINIA</i>		
24. FUNERAL DIRECTOR <i>William M. Hyson</i>			ADDRESS <i>WASH., D.C.</i>			25a. REC'D BY REG. STRAR DATE <i>MAR 18 1969</i>			25b. REGISTRAR'S SIGNATURE <i>John G. Ball</i>		
HYSON'S FUNERAL HOME-1300 -N STREET, N.W.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
Albert S. Anderson						Month 3 Day 5 Year 1969		PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 IF UNDER 1 YEAR MONTHS DAYS	
M		W		11-13-99		69 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md.	
Illinois		U.S.				Montgomery			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Rockville			Potomac Valley Nursing Home					Telephone Co.	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET AND NUMBER		
Rockville Md.			Montgomery		YES		503 Goldsboro Drive		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Unknown			Unknown						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT Address				
Yes			319-03-9427		Mrs. Frank Leone-same item # 13-Daughter				
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC BRAIN SYNDROME									1 1/2 YEARS
DUE TO OR AS A CONSEQUENCE OF (b) GENERALIZED ARTERIOSCLEROSIS									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c) PARKINSON'S DISEASE									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
CHRONIC URINARY TRACT INFECTION									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from FEB 15, 1969, to MAR 5, 1969, that (I) (we) last saw the deceased alive on MAR 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE						DEGREE		22c. DATE SIGNED	
Robert C. Daddario						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		MAR 5 1969	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
ROBERT C. DADDARIO						5413 CEDAR LANE BETHESDA			
23a BURIAL, CREMATION, or other disposition		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		3/8/69		Gate of Heaven		Silver Spring, Montg. Md.			
24 FUNERAL DIRECTOR ADDRESS						25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home 1331 Rock Pike Rockville, Maryland						MAR 10 1969		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

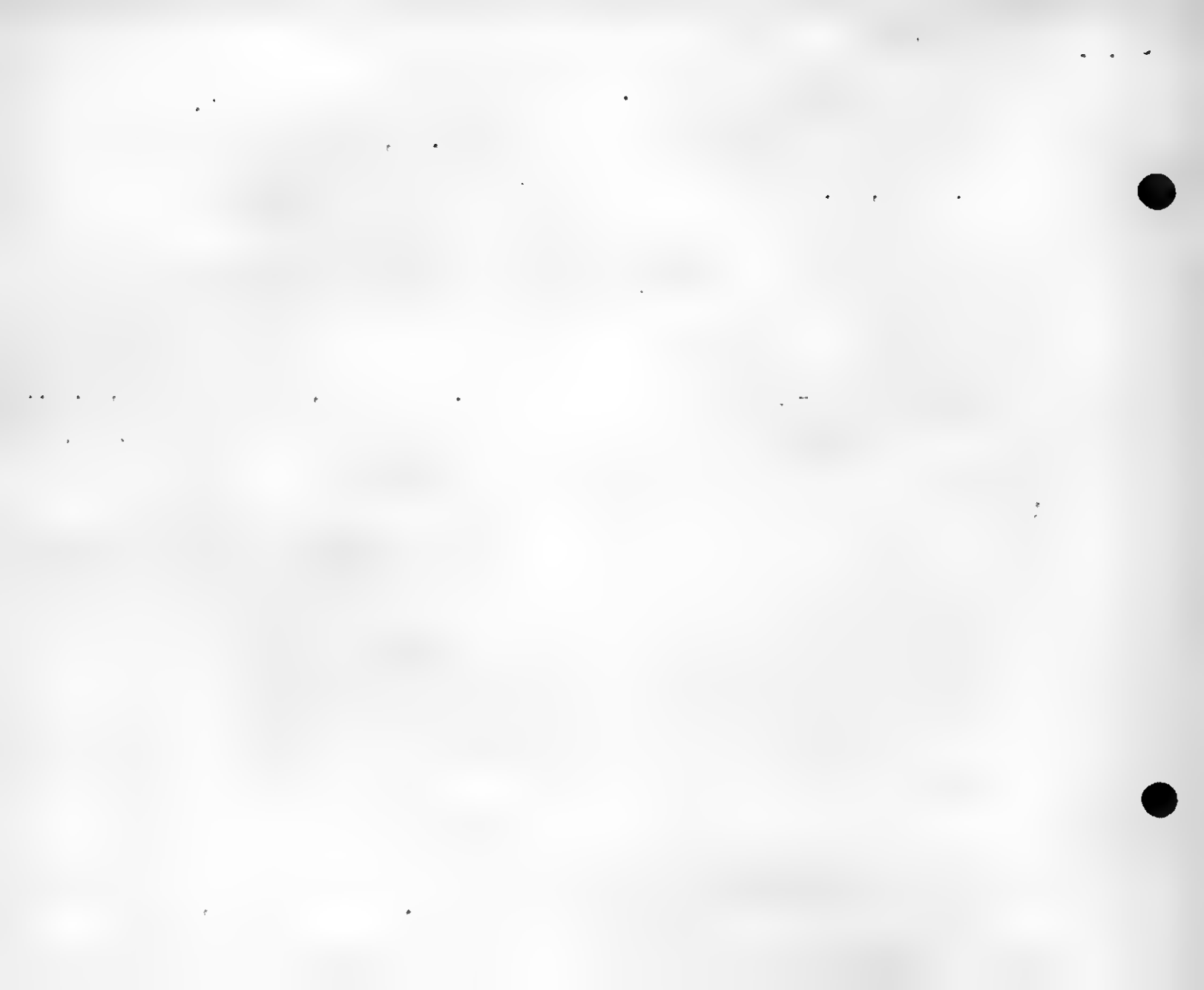
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04002										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03995				
Item 1 Film 410 3/27/69 kk										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
JAMES					MI H. ANDERSON					MARCH 14 1969					5:55 A.M.									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS									
MALE			WHITE			7/3/15			53 YRS.			MONTHS DAYS HOURS MIN												
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH									
VA.					U.S.A.										MONTGOMERY Md									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY									
SILVER SPRING					HOLY CROSS					Montg. Co. Employee														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS					13e. STREET AND NUMBER				
MARYLAND					MONTGOMERY					POOLESVILLE					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
Henry Anderson					Susie Latten																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address									
No					218-30-3813					Mrs. Mae Anderson					Pooleville Md									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable Coronary artery thrombosis</u>															Instant									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis obliterans</u>																								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Repeated Surgery for b/</u>																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
					HOUR A.M. Month Day Year P.M. 19																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)					21f. LOCATION					Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>11/16, 1968</u> , to <u>3/14, 1969</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE										DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED				
<u>W. Marcus Hill</u>																				3/14/69				
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS														
WILLIAM MARCUS, M.D.										10620 Georgia Ave., Sil. Spr., Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					3/17/69					Monacacy					Reasville Montg Md.									
24. FUNERAL DIRECTOR					ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE									
William B. Hillen, Bransville, Md.										MAR 18 1969					Charles J. Jones									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First GEORGE			Middle M.		Last ARROWSMITH			
2a. DATE OF DEATH			Month 17 , Day 1969 Year			2b. HOUR		7A M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH Aug. 28, 1886		6. AGE (In years last birthday) 82 YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign) ST. LOUIS, MO.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		Md			
10. CITY OR TOWN OF DEATH CHEVY CHASE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7201 MEADOW LANE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED		12b. KIND OF BUSINESS OR OCCUPATION ARMY OFFICER					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE		13d. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7201 MEADOW LANE			
14. FATHER'S NAME First Middle Last GEORGE - ARROWSMITH			15. MOTHER'S M. DEN NAME First Middle Last ROSETTA - CHARTRAND								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service) YES 1908-1946			16b. SOCIAL SECURITY NO. 220-44-5825		17. INFORMANT Address ANNE R. ARROWSMITH, 7201 MEADOW LANE, CH. CH., MD						
MEDICAL CERTIFICATION								18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
								PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Right middle cerebral thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
								DUE TO, OR AS A CONSEQUENCE OF (b) cerebral arteriosclerosis		years	
								DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis		years	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) arteriosclerotic heart disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5-15 , 19 66 , to 3-17 , 19 69 , that (I) (we) last saw the deceased alive on 3-16 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Oscar Mann M.D.		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3-17-69					
22d. PHYSICIAN'S NAME (Type) OSCAR MANN M.D.		22e. ADDRESS 2141 K ST. WASH DC									
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/19/1969		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.		23d. LOCATION (City or Town, County, State) ARLINGTON, VIRGINIA (State)					
24. FUNERAL DIRECTOR JOS. BAWLER'S SONS, 5130 WIS. AVE, WASH, D.C.		ADDRESS		25a. RECD. BY REGISTRAR MAR 20 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04004

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03997

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
VERNON SHIELDS AULD						OF ESTI-MATED <input type="checkbox"/> #XX 3-22-1969			3-22-1969			4:34 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male	White	1-21-88	81 YRS	MONTHS	DAYS	HOURS	Min.	Month Day Year			3-22-1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH						
Md.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY						
Takoma Park		Wash. San. & Hop.		Retired Accountant		Station						
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Md.		Mont.		S.S.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1123 Corliss St.				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Edwin Auld						Emma Shields						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS						
yes		WWI		220-44-7558		Mary Jane Auld, 11112 Ralston Rd., Rockville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Arrhythmia</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
CAUSE OF DEATH		HOUR A.M. P.M.										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED								
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		3/22/1969								
Belden R. Reap M.D.		DEPUTY MEDICAL EXAMINER										
		ADDRESS (Street, City, County, State)										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		Mar. 25, 1969		Rock Creek Cemetery		Washington, D.C.						
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE						
Paul E. Smith		8434 Georgia Avenue		DATE MAP 27 1969		Warner E. Humphrey, Inc.		Silver Spring, Md.				

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FOR STATE HEALTH DEPT.

04005

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

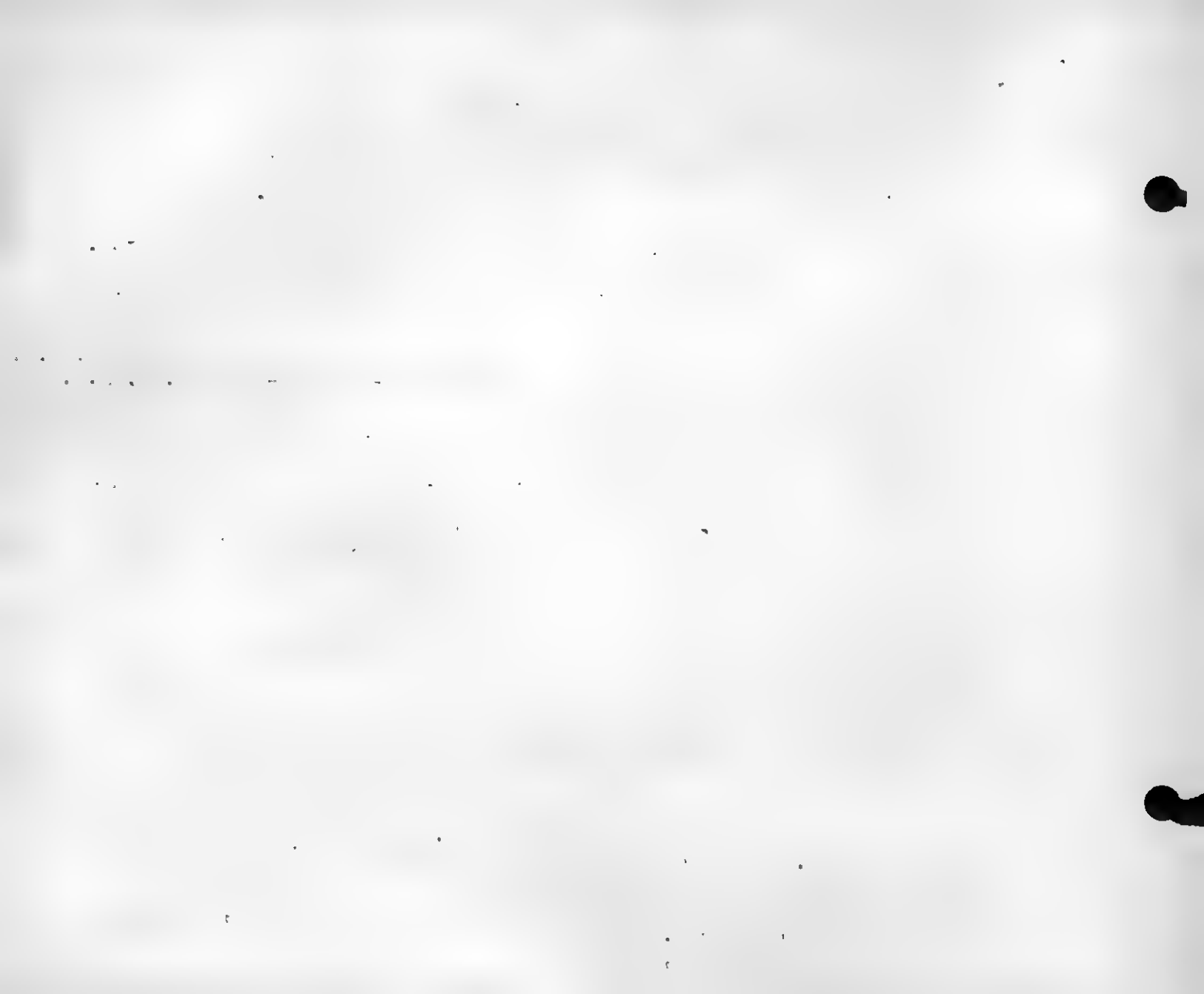
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03998

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		2b HOUR
William Edwin Baker					ESTIMATED <input checked="" type="checkbox"/> MARCH 21 1969		7:00 PM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR	F UNDER 24 HRS	2c DATE PRONOUNCED DEAD
M.	W.	July 27, 1916		52 YRS	MONTHS	DAYS	March 22 1969
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9 COUNTY OF DEATH		
Maryland		U.S.A.		W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>	Montgomery Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Rockville		504 Beall Ave.		Building Inspector		Montg. County	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		3e STREET AND NUMBER			
Jessie Baker		Perry Baker-Brother-		504 Beall Ave.			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT			
Yes		WWII		Perry Baker-Brother- Washington, D.C. ADDRESS 4117 W.St. N.W.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gastro Intestinal Hemorrhage-Massive</u> 5710 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophageal Varices</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cirrhosis of Liver (Laennec's)</u> Approximate interval between onset and death 5 min. Months. years.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		HOUR A.M. P.M. 19					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b DATE SIGNED			
John G. Ball		7936 Old Georgetown Rd. MD		March 23, 1969			
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)			
John G. Ball-Bethesda, Maryland							
23a BURIAL CREMATION, (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		3/27/69		Parklawn Cemetery		Rockville, Maryland	
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Tyson Wheeler		MAR 26 1969		Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04006

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03999

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Baby Girl Boy			2a. DATE OF DEATH Month March Day 14 Year 1969			2b. HOUR 6:35 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 14, 1969		6. AGE (In years last birthday) — YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12200 Braxfield Court	
14. FATHER'S NAME First Vernon Middle Allen Last Ball			15. MOTHER'S MAIDEN NAME First Mickey Middle Lee Last Sisler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mother					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 777X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Marvin Mowes				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3/14/69			
22d. PHYSICIAN'S NAME (Type) MARVIN MOWES M.D.				22e. ADDRESS 9801 G.A. Ave Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/20/69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				ADDRESS 1331 Rock Pike Rockville, Md.		25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) IVA			First P. Middle BALLARD Last			2a DATE OF DEATH Month 3 Day 19 Year 1969		2b HOUR 10 a M	
3 SEX F		4 RACE CAU		5 DATE OF BIRTH 3/23/14		6 AGE (In years last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY			
10 CITY OR TOWN OF DEATH CHEVY CHASE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5502 MONTGOMERY ST.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SALES GIRL		12b KIND OF BUSINESS OR INDUSTRY CONCESSION			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE WASH. D.C.		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3601 CONN. AVE. N.W. #306	
14. FATHER'S NAME First ISSAC Middle FRED Last PHOEBUS			15 MOTHER'S MAIDEN NAME First SADDIE Middle GREEN Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		(If yes give war or dates of service)		16b SOCIAL SECURITY NO. 218-16-8889		17. INFORMANT Address JAMES TAYLOR 5502 MONTGOMERY ST. MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Severe Brain Damage</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral vascular blood</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> , 19 <u>68</u> , to <u>3/8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/8</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stanley A Schwartz</u> M.D.					22c. DATE SIGNED <u>3/8/69</u>				
22d. PHYSICIAN'S NAME (Type) STANLEY SCHWARTZ M.D.					22e. ADDRESS 2400 "H" ST. N.W. WASH. D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-11-69		23c. NAME OF CEMETERY OR CREMATORY Monhain Cemetery		23d. LOCATION (City or Town) (County) (State) Princess Anne Maryland			
24 FUNERAL DIRECTOR Robert A Pumphrey 7557 Bethesda, Md					25a. REC'D BY REG. STRAR MAR 12 1969		25b. REGISTRAR'S SIGNATURE		

04008

CERTIFICATE OF DEATH

04001

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN IS <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>9510 Hale Place</u>	
3. NAME OF DECEASED (Type or print) <u>ISADORE</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1969</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/16</u>
9. AGE (In years last birthday) <u>52 yrs</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grocery/butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Itzik Barr</u>		14. MOTHER'S MAIDEN NAME <u>Ida X Tarkovskaya</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W. 11</u>		16. SOCIAL SECURITY NO <u>579-01-3083</u>	
17. INFORMANT <u>Daughter/ Sandra Smith, 12303 Barbara Road</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis. Acute</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Ht. Dis.</u> (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1968, to <u>Feb. 25</u> , 1969, that (I) (we) last saw the deceased alive on <u>Feb. 25</u> , 1969, and that death occurred at <u>11:15 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Isidore Shulman</u> M.D.		22b. DATE SIGNED <u>3-24-69</u>	
22c. PHYSICIAN'S NAME (Type) <u>ISIDORE SHULMAN</u>		22d. ADDRESS <u>915 19th ST. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Mar. 26, 1969</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Lebanon Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hyattsville, Maryland</u>
24. FUNERAL DIRECTOR <u>Donald M. Stein</u>		25a. REC'D. BY REGISTRAR <u>28 1969</u>	
Hebrew Memorial Funeral Home		25b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED WITH DR. REAP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
04009										
04002										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR M		
EMMA LOUISE BARRETT						3 Month 1 Day 1969				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		Negro		8/10/1880		88 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
No. Carolina		USA				Montgomery Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Wheaton			Univ. Nurs. Home			School teacher				
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before death) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Washington, DC							YES		5013 Jay St., NE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Wyatt Harper			?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address					
no			none		Gracie Swinson-5013 Jay Street, NE. Daugh.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF <u>chronic atherosclerosis</u> Conditions if any, which gave rise to immediate cause (a) <u>storing the underlying cause</u> last. (b) <u>chronic</u> (c) <u>chronic</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>chronic pyelonephritis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> , 19 <u>68</u> , to <u>2/12</u> , 19 <u>69</u> , that (we) last saw the deceased alive on <u>2/12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>David Morowitz, M.D.</u>					ATTENDING PHYSICIAN DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
David Morowitz, M.D.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3-7-69		Church Cemetery		Tarboro, North Carolina				
24. FUNERAL DIRECTOR John T. Rhines Co. Funeral Home 3015 12th Street, NE., Washington, D. C.						25a. REC'D BY REGISTRAR DATE MAR 6 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04010		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04003	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First ROSIE Middle MARY Last BEALL					2a. DATE OF DEATH Month 3 Day 3 Year 69		2b. HOUR 10 P.M.
3. SEX Female	4. RACE White		5. DATE OF BIRTH 3-2-72		6. AGE (In years last birthday) 97 YRS	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) White Oak, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1201 Harper Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home	
13a. USUAL RESIDENCE (Where deceased resides, if institution) Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1201 Harper Rd.		13f. CITY OR TOWN Silver Spring		13g. STATE Maryland			
14. FATHER'S NAME First George Middle Harper Last Harper			15. MOTHER'S MAIDEN NAME First Mary Middle Hopkins Last Hopkins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown		16b. SOCIAL SECURITY NO. 220-14-2203		17. INFORMANT Mrs. Jone Sorensen Address 1201 Harper Road Silver Spring, Maryland			
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A.S.H.D.							10 yrs
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from NOV , 1963, to 3-3, 1969 , that (I) (we) last saw the deceased alive on 3-3, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE D. J. Sengstack				22c. DATE SIGNED 3-3-69			
22d. PHYSICIAN'S NAME (Type) G. J. Sengstack				22e. ADDRESS 2201 Columbia Blvd. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 7, 1969		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City or Town) (County) (State) Forest Glen, Maryland-Mont. Ctu.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First Gussie			Middle None			Last Bean		
2a. DATE OF DEATH		3 Month			24 Day			69 Year		
2b. HOUR		10P			M					
3. SEX		Male			4. RACE			White		
5. DATE OF BIRTH		July 24 1877			6. AGE (In years last birthday)			91 YRS		
7a. BIRTHPLACE (State or foreign country)		W. Va.			7b. CITIZEN OF WHAT COUNTRY?			U.S. A.		
8. MARRIED		<input type="checkbox"/> NEVER MARRIED			<input checked="" type="checkbox"/> WIDOWED			<input type="checkbox"/> DIVORCED		
9. COUNTY OF DEATH		Montgomery			10. CITY OR TOWN OF DEATH			Rockville		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12701 Gould Rd			12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)			Farmer		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		W. Va.			13b. COUNTY			Hampshire		
13c. CITY OR TOWN		Baker			13d. STREET AND NUMBER			Baker, W. Va		
14. FATHER'S NAME		First Edmund			Middle Bean			Last Evans		
15. MOTHER'S MAIDEN NAME		First Margaret			Middle Baker			Last W. Va.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		No			16b. SOCIAL SECURITY NO			none		
17. INFORMANT		Marvin Bean			Address			Baker, W. Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work										
22a. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , 19 <u>66</u> , to <u>3-24</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 24</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED			22d. ADDRESS					
<u>A.W. Smith M.A.</u>		3-24-69			13018 GEORGIA AVE W. HEATON, MD					
22d. PHYSICIAN'S NAME (Type)		A.W. SMITH			22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		3-27-69			Asbury Cemetery			Baker, West Virginia		
24. FUNERAL DIRECTOR		24a. ADDRESS			24b. REC'D BY REGISTRAR			24c. REGISTRAR'S SIGNATURE		
Robert A Pumphrey		7557 Wisconsin Ave Bethesda, Md			APR 1 1969			<u>William J. Judge</u>		



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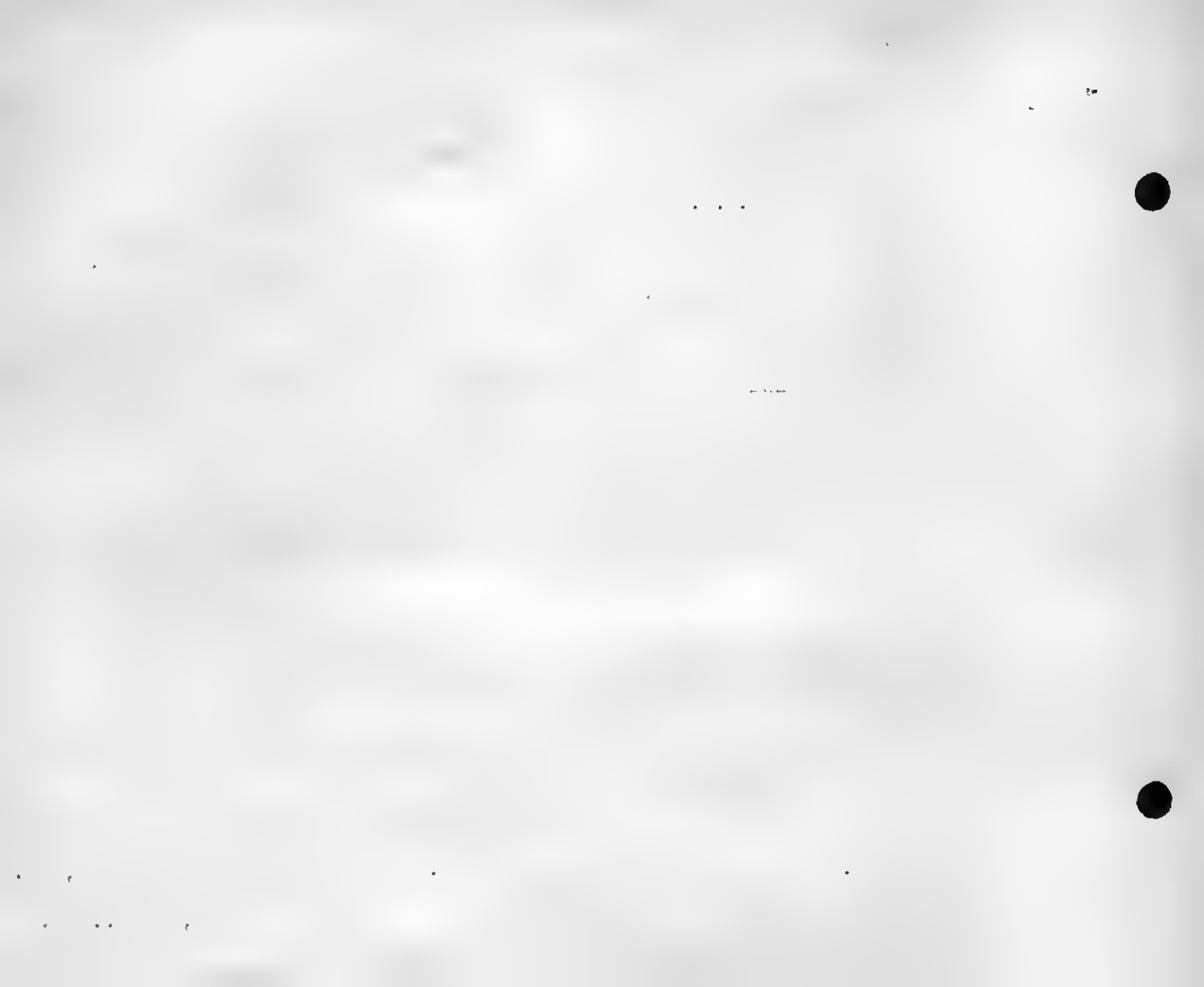
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04012					04005					
Item 7 Film 10 3/14/69 kk					CERTIFICATE OF DEATH					
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	
Yetta							Becker		3 Month 5 Day 69 Year	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		2b. HOUR	
Female		White		9/15/77			91 YRS.		11:30 PM	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
ENGLAND			U.S.A.					MONTGOMERY MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Holy Cross Hosp.			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Montgomery		CHCH.				4701 WILLARD AVE	
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME	
Abraham							Weisenberg		Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address	
Yes, no, or unknown						Son-in-law			4701 Willard Ave CHCH Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable bronchopneumonia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>400 X</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Renalized arterio sclerosis</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION		Street or R.F.D. No.		City or Town
										County
										State
22a. I certify that (I) (this hospital) attended the deceased from <u>2-23, 1969</u> , to <u>3-5, 1969</u> , that (I) (we) last saw the deceased alive on <u>3-5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE			22c. DATE SIGNED							
Att. Danish MD			3-6-69							
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
ABRAHAM W. DANISH			1106 Spruce St. S.E. DC							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			3-7-69		CHEV. SHOLOM-TALMUD TARA			WASHINGTON DC		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
BERNARD DANZANSKY & SONS - WASHINGTON DC			DATE			MAR 11 1969				



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15
45M

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)		First Elizabeth		Middle P.		Last Bendell		2a DATE OF DEATH March Month 13 Day 69 Year		2b HOUR 12 P M
3 SEX Female		4 RACE White		5 DATE OF BIRTH 7/30/1890		6 AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Mass.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				MD
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY Buyer				Dept. Store
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b COUNTY Mont.		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 199 Rollins Avenue		
14 FATHER'S NAME First Thomas		Middle Maloney		Last Delia		15 MOTHER'S MAIDEN NAME First Delia		Middle Hayes		Last Hayes
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown) (If yes give war or dates of serv. etc.) No		16b SOCIAL SECURITY NO 078 10 6545		17 INFORMANT Daughter-Mrs. Joseph McNulty		1014 Welsh Dr. Address Rockville, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive cardiovascular disease</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (1) (this hospital) attended the deceased from Feb. 12, 1958, to March 13, 1969, that (1) (we) last saw the deceased alive on Jan. 17, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death										
22b SIGNATURE G. Bowditch Hunter		22c DATE SIGNED March 13, 1969		22d PHYSICIAN'S NAME (Type) G. Bowditch Hunter		22e ADDRESS 50 W. Edmonston Drive, Rockville, Md.				
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE 3/15/69		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION (City or Town) (County) (State) Silver Spring, Montg. Md.				
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Maryland		25a REC'D BY REGISTRAR MAR 17 1969		25b REG. STRAR'S SIGNATURE J. L. Brown						



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04014

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04007

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR				2b. HOUR
ALFRED			H.	BENNA	MAR 25 1969				7:30 AM
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years not birthday)	7 UNDER YEAR		8 IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD
MALE	WHITE	5/10/12		56 YRS	MONTHS DAYS		HOURS MIN		Month Day Year 1969
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
PENNA		U. S. A.				Montgomery Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		SUBURBAN				COUNSELLOR		PRIVATE CH - School	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		MONTGOMERY		GAITHERSBURG				3 Tulip Drive	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
TILLMAN K		BENNA		BERTHA PEARL MURRY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
NAVY		Ward II		098-03-0573 WIFE FRY D BENNA SAME					
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>INTRACEREBRAL Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>MASSIVE SKULL FRACTURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Trauma from fall down stairs</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 MIN</u> <u>11</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 7:12 PM 3-29 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Fall down stair stairs</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F.D. No <u>3 Tulip Drive</u>		City or Town <u>Gaithersburg</u>		County <u>Montgomery</u>	
21g. LOCATION State <u>MD</u>		22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>March 29, 1969</u>			
EXAMINER'S NAME (Type) John G. Ball		7936 Old Georgetown Rd Bethesda, Maryland				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 1, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Church Cem.</u>		23d. LOCATION (City or Town) <u>Bedford, Pa.</u>		(County) (State)	
24. FUNERAL DIRECTOR <u>Tyson Wheeler F. H. 1331 Rockville Pike</u>				25a. REC'D BY REGISTRAR <u>APR 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
Rockville, Maryland									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
04015			04008								
DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR PM		
Dewey Sampson Bennett						March 17 1969			11:50		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
Male		Negro		1 * 21 - 14		55 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
North Carolina			Montgomery						Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park, Md.			Washington Sanitarium			Janitor					
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Montgomery			Silver Spring			8110 Tahona Dr. #101		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Junius N. Bennett			Lula C. Sampson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address			Silver Spring Md.		
						Helen Bennett - 8110 Tahona Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory and Myocardial Failure</u>										2 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Brain Syndrome</u>										56 hrs	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cirrhosis of Liver Advanced (Nutritional)</u>										Unknown	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carcinoma of Esophagus</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (H) (this hospital) attended the deceased from <u>March 13, 1969</u> , to <u>March 17, 1969</u> , that (H) (we) last saw the deceased alive on <u>March 17, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Allen H. Trause</u> M.D. DEGREE						ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>March 18, 1969</u>		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS <u>8237 Georgia Ave. Silver Spring Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			3-22-69			Lincoln Memorial Cemetery			Suitland, Maryland		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE		
<u>John T. Rhine</u> 3015-12 th St. N.E.						MAR 24 1969			<u>Charles Judge</u>		

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with n172 holds after death.

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Eidson C.</i>		First <i>C.</i>		Middle <i>Beahm</i>		Last		2a. DATE OF DEATH Month <i>3</i> Day <i>18</i> Year <i>1969</i>			2b. HOUR <i>5:45</i> AM	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>6-29-16</i>		6. AGE (In years last birthday) <i>52</i> YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (Store or foreign country) <i>N.Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.						
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Nurse</i>		12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8711 Maywood Ave. Silver Spring, Md.</i>				
14. FATHER'S NAME First <i>Reuben</i>		Middle <i>Cutter</i>		Last		15. MOTHER'S MAIDEN NAME First <i>Beatrice</i>		Middle <i>Mollie</i>		Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>089-22-5661</i>		17. INFORMANT Address <i>S.S. Lyle Berlin, Son, 8711 Maywood Ave. Md.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic Carcinoma from Pancreas</i> <i>1574</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION <i>March '68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>neck node</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (the hospital) attended the deceased from <i>Feb 10, 1965</i> to <i>18 March 1969</i> , that (I) (we) last saw the deceased alive on <i>17 March 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Ira N. Tublin</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>March 18, 1969</i>						
22d. PHYSICIAN'S NAME (Type) <i>Ira N. Tublin, Md.</i>		22e. ADDRESS <i>800 Pershing Dr., Silver Spring, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/19/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Montefiore Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>L. I., N. Y.</i>						
24. FUNERAL DIRECTOR <i>Bernard Danzansky & Sons,</i>		ADDRESS <i>3501 14th St. NW, Wash., D.C.</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 20 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Vetter</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) Sylvia Cummings Betts.			2a DATE OF DEATH Month MAR Day 21 Year 1969			2b. HOUR 6:10 PM			
3 SEX FEMALE		4 RACE CAUC		5 DATE OF BIRTH 11-1-09		6 AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS 4 DAYS 20	
7a BIRTHPLACE (State or foreign country) England		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH BROOKMONT		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 6506-RIDGE DR		12a USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired) EDITOR		12b KIND OF BUSINESS OR INDUSTRY FILM			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD		13b CITY OR TOWN BROOKMONT		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET AND NUMBER 6506-RIDGE DR			
14 FATHER'S NAME First HUBERT Middle ST. GEORGE Last CUMMINGS		15 MOTHER'S M.A.DEN NAME First LUCIE Middle H. Last SHERWILL							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) No		16b SOCIAL SECURITY NO 579-50-5686		17 INFORMANT THOMAS I BETTS		Address 6506-RIDGE DR			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction stat DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease unkn. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic congestive heart failure									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic congestive heart failure									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (1) (this hospital) attended the deceased from JAN , 1969, to MAR 21 , 1969, that (1) (we) lost saw the deceased or on MAR 20 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (d) (did not) view the body after death.									
22b SIGNATURE Robert S. Poole		DEGREE PHYS		ATTENDING <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED MAR 21, 1969			
22d. PHYSICIAN'S NAME (Type) Robert S. Poole		22e ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b DATE 3-24-69		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) Suitland		(County) Maryland	(State)
24. FUNERAL DIRECTOR Robert A. Pumphrey				7557-Wisconsin Ave., Bethesda, Md.		25a REC'D BY REGISTRAR MAR 26 1969		25b REGISTRAR'S SIGNATURE Charles J. Jones	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04018

04011

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b HOUR
HAROLD F. Bichsel					ESTIMATED <input type="checkbox"/> 3 1 1969					10 58 AM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD	
Male	White	July 28, 1905		63 YRS	MONTHS DAYS		HOURS MIN		Month 3 Day 1 Year 1969	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Ohio		U.S.A.				Montgomery Md				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Bethesda		Suburban Dist.				Sales Manager		B.F. Goodrich		
13a U.S.A. RESIDENCE (Where deceased lived, if not institution admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.		Mont.		Cherry Chase				4708 Falstone Ave		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S M.A.DEN NAME		First	Middle	Last	
Frederick Bichsel					Estelle Hoppes					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS				
No		297-10-5718		Wife - Nellie Bichsel		Same				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>										Sudden
4123 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost										Years
(b) <u>Cardiovascular Disease</u>										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. P.M. 19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED				
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)						
JOHN G. BALL		BETHESDA, MONTGOMERY Md.		Bethesda, Md.						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		County		State
BURIAL		MARCH 5 1969		HIGHLAND MEMORIAL PARK		ALLIANCE OHIO				
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY				7557 WISC. AVE BETHESDA Md.		MAR 5 1969		Charles Judge		

04019

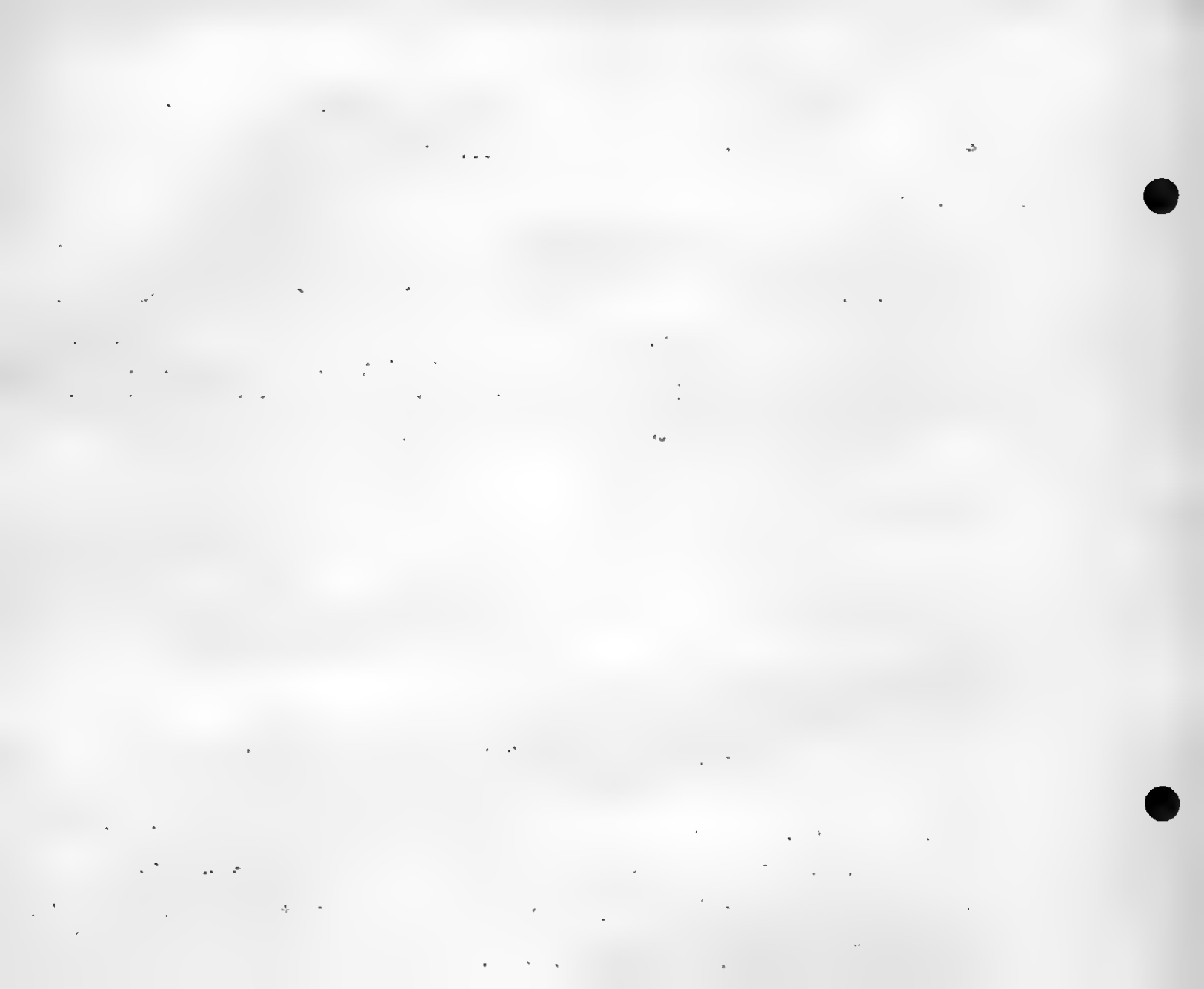
CERTIFICATE OF DEATH

04012

1 DECEASED-NAME (Type or print) Wilford			First Middle Last			2a. DATE OF DEATH Month March Day 25 Year 69			2b. HOUR 505P M		
3 SEX Male			4 RACE Negro			5. DATE OF BIRTH Oct. 14, 1922			6. AGE (In years last birthday) 46 YRS		
7a. BIRTHPLACE (State or foreign country) N. Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Diet Cook			12b. KIND OF BUSINESS OR INDUSTRY Food		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C.			13b. COUNTY Washington			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 1252 Owen Place, N. E.			14 FATHER'S NAME First Jessie Middle Bivens Last Lessie			15 MOTHER'S MAIDEN NAME First Lessie Middle Marshall Last Marshall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 9373294			17 INFORMANT Washington, D. C. Mrs. Elaine Bivens, 1706 Hobart St. N.W.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Broncho Pneumonia 495X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Mar. 25, 1969 , to Mar. 25, 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Mar. 25, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.											
22b. SIGNATURE R. D. Gaskins						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED Mar. 27, 1969		
22d. PHYSICIAN'S NAME (Type) R. D. Gaskins, M. D.						22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, or other disposition (Specify) Burial			23b. DATE 3-13-69			23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va.		
24. FUNERAL DIRECTOR Latney Funeral Home ADDRESS 3831 Georgia Ave., N.W. Washington, D. C.						25a. REC'D BY REGISTRAR APR 1 1969			25b. REGISTRAR'S SIGNATURE R. D. Gaskins		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

188-22a Form 413 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04020

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04013

1. DECEASED NAME (Type or Print) <i>Erwin Richard Bogenrieder</i>		First Middle Last		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3 31 1969		2b. HOUR 5:45 M	
3 SEX <i>male</i>	4 RACE <i>white</i>	5 DATE OF BIRTH <i>3-30-36</i>	6 AGE (in years last birthday) <i>33</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month <i>March</i> Day <i>31</i> Year <i>1969</i>	
7a. BIRTHPLACE (State or foreign country) <i>Buffalo, N. Y.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Rockville</i>		1. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. give street address) <i>1902 Valley Stream Dr.</i>		2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>N.I.H. Contract Specialist</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. ASIDE CITY, STATE? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>German Bogenrieder</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Hulda Haas</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <i>125-28-8911</i>		17. INFORMANT <i>Martha L. Bogenrieder</i>		ADDRESS <i>Same as #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pend. Ppl. Encephalitis Acute Lymphocytic</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Viral infection</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>24 hrs.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John G. Bell</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <i>March 31, 1969</i>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-3-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring Mont., Md.</i>	
24. FUNERAL DIRECTOR <i>Francis J. Collins</i> ADDRESS <i>500 University Blvd. Silver Spring, Md.</i>				25a. REC'D BY REGISTRAR <i>APR 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04021

CERTIFICATE OF DEATH

04014

1 DECEASED-NAME (Type or print) HARRY W. Bowers		First Middle Last		2a. DATE OF DEATH Month 3 - Day 15 - Year 69		2b. HOUR 8:30 PM	
3 SEX MALE		4 RACE white		5 DATE OF BIRTH Oct. 9th - 82		6 AGE (n years last birthday) 88 YRS	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Md.		13b COUNTY Montgomery		13c CITY OR TOWN Catharsburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER Free state apts #7		14 FATHER'S NAME John Bowers		15 MOTHER'S MAIDEN NAME Mandelia Hershberg			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b SOCIAL SECURITY NO 217-01-5434		17 INFORMANT Iva Rupp		Address 859 Broadhurst Baltimore Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiovascular collapse 428 X DUE TO, OR AS A CONSEQUENCE OF (b) multiple emboli DUE TO, OR AS A CONSEQUENCE OF (c) myocarditis Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
9a DATE OF OPERATION		9b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or RFD No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from March 2, 1969 , to March 15, 1969 , that (I) (we) last saw the deceased alive on March 15, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE W. B. Ehrmantrant MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3/19/69	
22d PHYSICIAN'S NAME (Type) W. B. Ehrmantrant		22e ADDRESS 1125 Rockville Pike Rockville					
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 3-18-69		23c NAME OF CEMETERY OR CREMATORY Pine Grove		23d LOCATION (City or Town) (County) (State) Bel Air Md. 20852	
24 FUNERAL DIRECTOR Ernest C. Gartner		ADDRESS Catharsburg Md.		25a REC'D BY REGISTRAR Charles Judge		25b REGISTRAR'S SIGNATURE Charles Judge	
DATE MAR 20 1969							

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04022

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04015

1 DECEASED NAME (Type or Print) Uelt - BRAZIEL			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month 3 Day 23 Year 1969			2b HOUR 6 PM	
3 SEX Male	4 RACE W	5 DATE OF BIRTH 9-11-01	6 AGE (In years last birthday) 67 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month 3 Day 23 Year 1969	
7a BIRTHPLACE (State or foreign country) Cal.		7b CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY	
10 CITY OR TOWN OF DEATH Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Healy Cross Hosp.		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b COUNTY PRINCE GEORGES		13c CITY OR TOWN HYATTSVILLE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 4001 WARNER AVE.		14 FATHER'S NAME First R.G. Middle Braziel Last Whitley		15. MOTHER'S MAIDEN NAME First Whitley Middle Whitley Last Whitley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16b. SOCIAL SECURITY NO NO		17. INFORMANT WIFE HYATTSVILLE, MD.		17. INFORMANT ANNA P. BRAZIEL 4001 WARNER AVE.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) White Coronary Insufficiency 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Read		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. READ, M.D.		ADDRESS (Street, city, town, or county) 3/23/1969		22b. DATE SIGNED 3/23/1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-27-69		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CENT.		23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.	
24. FUNERAL DIRECTOR Lee FUNERAL HOME		ADDRESS 600-4 ST NE DR		25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Alma Billie Brooke						March 24, 1969			12:45
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		White		March 4, 1910		59 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
North Carolina		America				Montgomery Md			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Takoma Park		Washington Sanitarium				Housewife			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Montgomery		Wheaton				11723 Highview Avenue	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
John					Hicks	Gertrude			Bolick
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT Address			
no			579-12-4017			Patient's chart			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Liver cancer</u> DUE TO, OR AS A CONSEQUENCE OF <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <u>3/5</u> , 19 <u>69</u> , to <u>3/25</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3/25</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED		22e ADDRESS					
<u>Lewis H. Dennis, MD</u>		<u>3/24/69</u>		<u>8306 Bulbre Rd. Silver Spring, Md.</u>					
22d PHYSICIAN'S NAME (Type)		22e ADDRESS		22f REGISTRAR'S SIGNATURE					
<u>Lewis H. Dennis, MD</u>		<u>8306 Bulbre Rd. Silver Spring, Md.</u>		<u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>					
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		25a. REGISTRAR'S SIGNATURE	
<u>Burial</u>		<u>3/27/69</u>		<u>Fort Lincoln Cemetery</u>		<u>Washington, D. C.</u>		<u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>	
24 FUNERAL DIRECTOR		25a. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
<u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>		<u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>		<u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>		<u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>		<u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04024

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04017

1. DECEASED NAME (Type or print) First Middle Last Wilbur Reynolds Brooks			2a. DATE OF DEATH Month Day Year March 14 1969			2b. HOUR a m 7:10	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 6 September 1911		6. AGE (In years last birthday) 57 YRS.	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital, Bethesda		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. Navy		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Delaware		13b. COUNTY Kent		13c. CITY OR TOWN Milford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER P.O. Box 411 RR#2		14. FATHER'S NAME First Middle Last Wilbur Brooks		15. MOTHER'S MAIDEN NAME First Middle Last unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 1930-1960		17. INFORMANT Margaret Brooks		Address P.O. Box 411 RR#2 Delaware	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) Aortic Stenosis							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12 March 1969 , to 14 March 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 18 March 1969 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE J. H. Hornbaker Jr MD				22c. DATE SIGNED 17 Mar 69			
22d. PHYSICIAN'S NAME (Type) J. H. HORNBAKER, JR., M. D.				22e. ADDRESS Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE 3/19/69		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION (City or Town) (County) (State) Milford, Del.	
24. FUNERAL DIRECTOR Berry Funeral Home				25a. REC'D BY REGISTRAR M. 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that Page 4 may be retained by the hospital or attending physician

VR A15
30M REV

04018

MEDICAL CERTIFICATION

24
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04026

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04019

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Willard Harrison Brown						March 28, 1969			3P. M.		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Aug. 29, 1888		80 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		USA				Montgomery Md.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Monrovia		RFD # 1		Farmer							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Montgomery		Monrovia				RFD # 1			
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John -- Brown						Frances -- Burdette					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address					
No				213-42-7422		Winfred W. Brown, R#1, Monrovia, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Enterosclerotic cardiovascular disease</u>										10 years	
4124 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 3/26, 1945, to 3/28, 1969, that (I) (we) last saw the deceased alive on 3/28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>James P. Kerr</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED March 29, 1969				
22d. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.					22e. ADDRESS Damascus, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		March 31, 1969		Mt. View		Pardum, Maryland					
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Olin L. Molesworth, Damascus, Md.					DATE APR 3 1969		<u>W. Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

04027

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04020

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Franklin			Richard	Brun	March 19 1969			12:30			
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		White		September 13, 1883		85 YRS					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
New York		America				Montgomery		Md			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park		Washington Sanitarium & Hosp		Protective Agency							
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Montgomery		Takoma Park				517 Albany Avenue			
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
John William Brun						Hadwig					Hanfield
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address					
no				120-12-6875		Patinet's chart					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST											
DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE										Months	
DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS										YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 3-17, 1969, to 3-17, 1969, that (I) (we) last saw the deceased alive on 3-17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John L. Ford M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3-19-69			
22d. PHYSICIAN'S NAME (Type) JOHN L. FORD M.D.						22e. ADDRESS 831 UNIVERSITY BLVD. SILVER SPRING, MD 20905					
23a. BURIAL - CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		March 21-1969		Washington Cemetery		Brownsville		T.C.			
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. REC'D BY REGISTRAR		24d. REGISTRAR'S SIGNATURE					
Arthur Walters		244 Carroll St. NW Washington, D.C. 20005		REC'D BY REGISTRAR		James Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>1 DECEASED NAME (Type or print)</div> <div>First Middle Last</div> <div>Estella Charlotte Bucknam</div>									
<div>2a. DATE OF DEATH</div> <div>Month Day Year</div> <div>March 22 1969</div>		<div>2b. HOUR</div> <div>3:25AM</div>							
<div>3. SEX</div> <div>Female</div>		<div>4 RACE</div> <div>White</div>		<div>5. DATE OF BIRTH</div> <div>June 13, 1874</div>		<div>6. AGE (in years lost birthday)</div> <div>94 YRS</div>		<div>F UNDER 1 YEAR</div> <div>IF UNDER 24 HRS.</div> <div>MONTHS DAYS HOURS MIN</div>	
<div>7a. BIRTHPLACE (State or foreign country)</div> <div>Wisconsin</div>		<div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>USA America</div>		<div>8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>9. COUNTY OF DEATH</div> <div>Montgomery Md.</div>			
<div>10. CITY OR TOWN OF DEATH</div> <div>Takoma Park</div>		<div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>Washington San & Hospital</div>		<div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)</div>		<div>12b. KIND OF BUSINESS OR INDUSTRY</div>			
<div>13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE</div> <div>Maryland</div>		<div>13b. COUNTY</div> <div>Montgomery</div>		<div>13c. CITY OR TOWN</div> <div>Rockville</div>		<div>13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>		<div>13e. STREET AND NUMBER</div> <div>17910 Cashell Road</div>	
<div>14. FATHER'S NAME</div> <div>First Middle Last</div> <div>Henry Taylor</div>		<div>15. MOTHER'S MAIDEN NAME</div> <div>First Middle Last</div> <div>Margaret Everhart</div>		<div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)</div> <div>no</div>					
<div>16b. SOCIAL SECURITY NO</div> <div>392-52-5510</div>		<div>17. INFORMANT</div> <div>Patient's Chart</div>							
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) SEPTICEMIA</div> <div>DUE TO, OR AS A CONSEQUENCE OF (b) PYELONEPHRITIS</div> <div>DUE TO, OR AS A CONSEQUENCE OF (c) INTRACTABLE INFECTION</div> <div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) stating the underlying cause last</div>									<div>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</div> <div>WEEKS</div> <div>MONTHS</div>
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)</div> <div>CONGESTIVE HEART FAILURE, CHRONIC</div>									
<div>19a. DATE OF OPERATION</div>		<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>		<div>20a. AUTOPSY?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div>		<div>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>			
<div>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)</div>		<div>21b. TIME OF INJURY</div> <div>HOUR A.M. Month Day Year</div> <div>P.M. 19</div>		<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)</div>					
<div>21d. INJURY OCCURRED</div> <div>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></div>		<div>21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)</div>		<div>21f. LOCATION</div> <div>Street or R.F.D. No City or Town County State</div>					
<div>22a. I certify that (I) (this hospital) attended the deceased from 2-6, 1967, to 3-22, 1967, that (I) (we) saw the deceased alive on 3-21, 1967, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.</div>									
<div>22b. SIGNATURE</div> <div>John L Ford MD</div>				<div>DEGREE</div> <div>MD</div>		<div>ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/></div>		<div>22c. DATE SIGNED</div> <div>3/22/69</div>	
<div>22d. PHYSICIAN'S NAME (Type)</div> <div>JOHN LOUIS FORD</div>				<div>22e. ADDRESS</div> <div>831 UNIVERSITY BLVD. SILVER SPRING MD. 20903</div>					
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>		<div>23b. DATE</div> <div>March 24, 1969</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Memorial Cemetery</div>		<div>23d. LOCATION (City or Town) (County) (State)</div> <div>Beallsville, Md.</div>			
<div>24. FUNERAL DIRECTOR</div> <div>Arthur Walters, 254 Carroll St N.W. Wash. DC</div>				<div>25a. REC'D BY REGISTRAR</div> <div>DATE MAR 24 1969</div>		<div>25b. REGISTRAR'S SIGNATURE</div>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04029

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04022

1. DECEASED-NAME (Type or print) Daisy May			First Middle Last			2a. DATE OF DEATH Month 3 Day 13 Year 69			2b. HOUR 6:25 PM					
3. SEX Female			4. RACE White			5. DATE OF BIRTH 6-29-82			6. AGE (In years last birthday) 86 YRS					
7a. BIRTHPLACE (State or foreign country) Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b. KIND OF BUSINESS OR INDUSTRY none					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Montg.			13c. CITY OR TOWN Silver Spg.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 10617 Tenbrook Dr.		
14. FATHER'S NAME James			First Middle Last			15. MOTHER'S MAIDEN NAME Louisa			First Middle Last Thompson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 78-16-5047 B			17. INFORMANT Records of Montgomery General Hosp.			Address Olney, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident														
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis														
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease														
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
Arteriosclerotic Heart Disease														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 69 , to 3/13 19 69 , that (I) (we) last saw the deceased alive on 5/12 19 69 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death														
22b. SIGNATURE Allan B. Cohan, M.D.						DEGREE MD ATTENDING <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 5/13/69					
22d. PHYSICIAN'S NAME (Type) Allan B. Cohan, M.D.						22e. ADDRESS 13515 Georgia Ave. Silver Spring, Md. 20906								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 17, 1969			23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.					
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.						25a. REC'D BY REGISTRAR 19 1969			25b. REGISTRAR'S SIGNATURE John J. Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04030

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04023

1 DECEASED NAME (Type or print) Annie Harrison Burwell			2a. DATE OF DEATH 3 Month 12 Day 69 Year			2b. HOUR M	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 9/30/1887		6. AGE (In years last birthday) 81 YRS.	
7a. BIRTHPLACE (State or foreign country) Statesville, N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) School teacher		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2822 Sherman Ave., N. W.		14. FATHER'S NAME First Middle Last Robert Murdock		15. MOTHER'S MAIDEN NAME First Middle Last Rebecca Austin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 579-60-9045		17. INFORMANT Dr. Hartford Burwell		Address see 13E Wash., D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 2309 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1 Sept</u> , 19 <u>68</u> , to <u>12 March</u> 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>11 March</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Walter E. Goosz</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>March 12 1969</u>	
22d. PHYSICIAN'S NAME (Type) Walter E. Goosz, M.D.				22e. ADDRESS 2309 Shorefield Road Silver Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/15/69		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION (City or Town) (County) (State) Highland Park, Maryland	
24. FUNERAL DIRECTOR <u>W. E. Goosz</u>				1820 9th St., N.W. Washington, D.C.		25a. REC'D BY REGISTRAR MAR 17 1969	
				25b. REGISTRAR'S SIGNATURE <u>W. E. Goosz</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

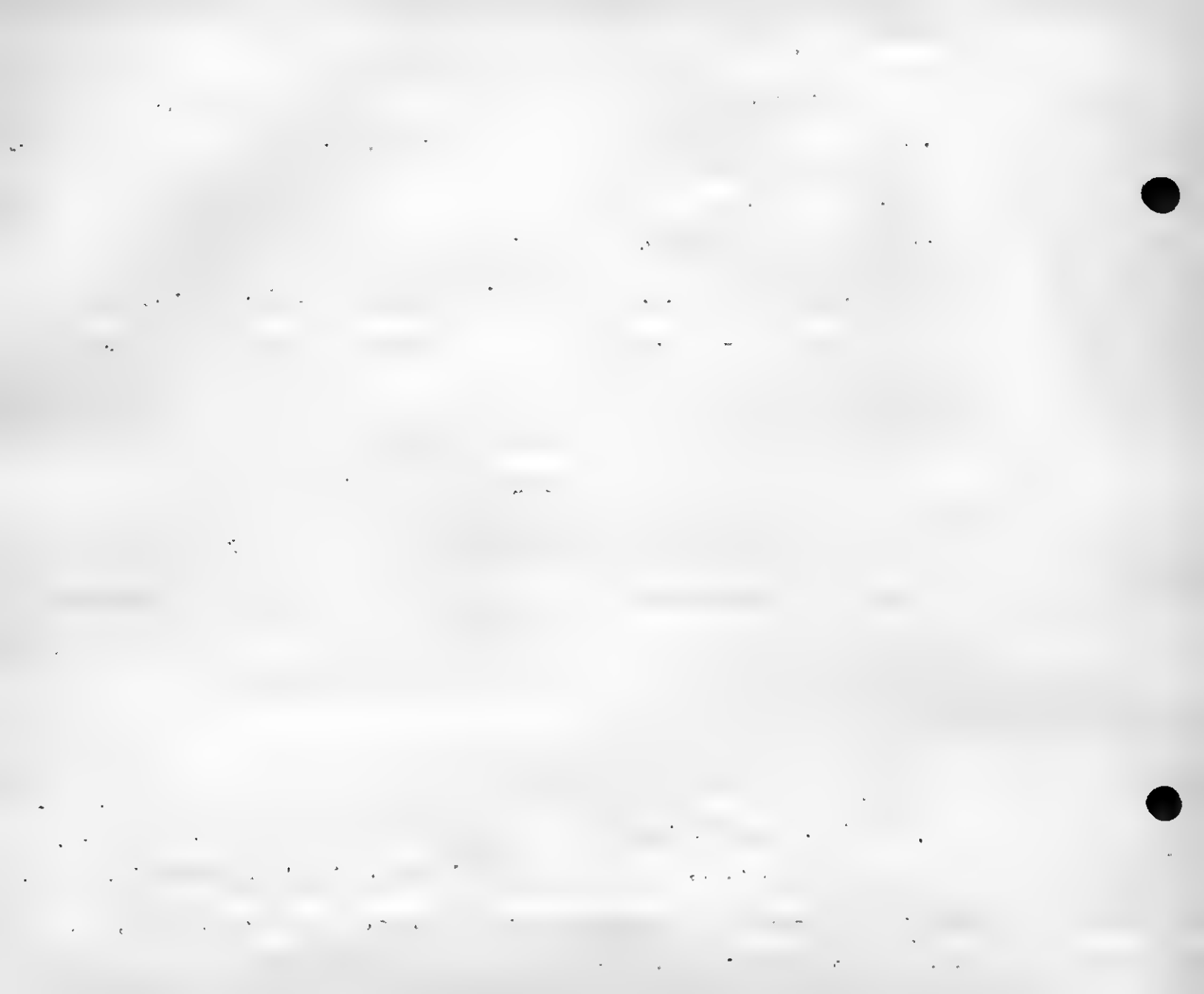
04031

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04024

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P		
Baby Boy			Butler			March 8, 1969			1:15 M		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH March 8, 1969		6. AGE (In years last birthday) YRS		7. UNDER YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5300 46th Ave.,		
14. FATHER'S NAME First Middle Last Irvin - Payne			15. MOTHER'S MAIDEN NAME First Middle Last Valeria Cecelia Butler								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO		17. INFORMANT Address Mother						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>IMMATUREITY</u> 7612 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PREMATURE DELIVERY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYDRAMNIOS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>N. Stoehr</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-8-69			
22d. PHYSICIAN'S NAME (Type) N. Stoehr, M.D.,						22e. ADDRESS 831 University Blvd., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 3-9-69		23c. NAME OF CEMETERY OR CREMATORY Washington San & Hospital			23d. LOCATION (City or Town) (County) (State) Takoma Park, Mont., Md.			
24. FUNERAL DIRECTOR J.D. Ruffcord, Takoma Park, Maryland						25a. REC'D BY REGISTRAR DATE MAR 11 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 4 Film 110

3/27/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04025

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month		Day		Year		2b. HOUR			
Maria		Casilda		Cabrejas				March 19		19		69		11A		M			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years first birthday)		7 FINDER YEAR		8 IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year		2d. HOUR	
Female	White	4-9-88		80		YRS		MONTHS		DAYS		HOURS		MIN		March 19		1969 11A M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH											
Cuba		U.S.A.		WIDOWED		DIVORCED		Montgomery										Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY													
Bethesda		Suburban Hospital		Housewife		Own home													
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER											
Md.		Montgomery		Wheaton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11919 Lafayette Drive											
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last					
Rafael		Manuela						Manuela						Corrales					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS													
		220-60-4706		Son - Joaquin Cabrejas		Same													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cerebral Hemorrhage -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		4 days											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		Cardio Vascular Disease & Diabetes Mellitus		years													
(c)		Arterio Sclerosis generalized -		years															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		Fracture of Lumbar Spine -																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No		City or Town		County		State									
		Home		11919 Lafayette Drive		Wheaton		Montgomery		Md									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from.		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED		19 March 1969							
EXAMINER'S NAME (Type)		John G. Ball, M.D.		ADDRESS (Street, city, town or county)															
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)									
Burial		March 22, 1969		Gate of Heaven Cemetery		Silver Spring		Montgomery		Md									
24 FUNERAL DIRECTOR		Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
		8434 Georgia Avenue		MAR 24 1969		Charles Judge													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04033		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04026	
1 DECEASED-NAME (Type or print) EDWIN			First	Middle H.	Lost CAGE	2a. DATE OF DEATH Month MARCH Day 4 Year 1969	
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH 11-5-10		6. AGE (In years last birthday) 58 YRS.	
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONT GOMERY	
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Civilian Employee Air Force		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 218 St. Lawrence Drive		13f. CITY OR TOWN Silver Spring, Md.		13g. STREET AND NUMBER 218 St. Lawrence Drive		13h. CITY OR TOWN Silver Spring, Md.	
14 FATHER'S NAME First Bernie Middle H. Last Cage			15. MOTHER'S MAIDEN NAME First Alma Middle Wilso Last Wilso				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO 213-16-3192		17 INFORMANT Mrs. Rebecca K. Cage		Address Silver Spring, Md.	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, unknown primary site 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Approx 10
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Oct 1968 to 3/4 1969 , that (I) (we) last saw the deceased alive on 3/3 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Leonard Gold				22c. DATE SIGNED 3/4/69			
22d. PHYSICIAN'S NAME (Type) G. Leonard Gold				22e. ADDRESS 9501 Gc. Ave Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE March 7, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR E. P. Phray, Inc. Silver Spring, Md.				25a. REC'D BY REGISTRAR DATE MAR 10 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the bur of transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

VR 410
45M - 110

04034		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04027	
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH	
PETER C CAMERON						Month	Day
3 SEX			4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	7b HOUR
MALE			WHITE	8-6-1896		12	40
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH	
PENNA.			USA		Montgomery		MD
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
Bethesda			SUBURBAN			RETIRED - SALES	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER
MD.			Montgomery		Bethesda	YES <input type="checkbox"/> NO <input type="checkbox"/>	4625 RIVER RD
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME	
WILLIAM W. CAMERON						LILLY	CARVEY
16a WAS DECEASED EVER Yes, no or unknown			16b SOCIAL SECURITY NO		17 INFORMANT		
YES			-		MRS. BETTY F. CAMERON, WIDOW, SAME #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Pulmonary Edema and Pleural Effusion</u>							2 days
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>Acute anterior myocardial infarction</u>							10 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<u>Coronary arteriosclerosis severe</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natlly medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
		HOUR A.M. Month Day Year					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>3/6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/5</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)			
<u>J. Blaine Tiggeraud M.D.</u>		<u>3/6/69</u>		<u>Bethesda Maryland</u>			
23a BURIAL CREMATION REMOVAL (Type)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
<u>Burial</u>		<u>3-8-1969</u>		<u>Parklawn Cemetery</u>		<u>Pockville, Montgomery Co., Md.</u>	
24 BY WHOM PREPARED		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
<u>Joseph Gawlor's Sons, Inc., 124 Wisc. Ave. N.W. Wash. D.C. 20015</u>		<u>MAR 10 1969</u>		<u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04035

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04028

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b. HOUR P	
Joseph Rodman Carpenter					March 24 1969		9:20 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
Male	White		3/21/90		79 YRS.			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Michigan	U.S.A.				Montgomery Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Olney		Montgomery General Hospital		Accountant				
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admision) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland		Montgomery		Sandy Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		1701 Norwood Road
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
William T. Carpenter					Ella M. Jackson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT records Address				
no		281-09-7070		Montgomery General Hospital, Olney, Md. 20832				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia Rt side</u>								<u>4 days</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus</u>								<u>YES</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>10/9/68</u> to <u>3/25/69</u> , that (I) (we) saw the deceased alive on <u>3/24/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.								
22b SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED		
						<u>3/25/69</u>		
22d. PHYSICIAN'S NAME (Type)		Charles H. Ligon, M.D.		22e. ADDRESS		Sandy Spring, Maryland		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Cremation		March 26 1969		Lee Funeral Home		Washington D.C.		
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Francis H. Barber		Laytonsville Md.		MAR 27 1969		<u>[Signature]</u>		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 11 & 15 Film 111
4/2/69 kkr

04036

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04029

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
James			Melvin			CARTER			2a DATE KNOWN OF DEATH MATED <input type="checkbox"/> Mar 12 1969 715 M 2c DATE PRONOUNCED DEAD Month Day Year 19 69 715 M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years by birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN					2d HOUR
Male	Negro	Oct 20, 1931	37 YRS								715 M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		USA				Montgomery			Md		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Bethesda			Naval Hospital			U. S. Marine Corps			N/A		
13a U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland						Baltimore			2730 Hugo Avenue		
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
James William Carter			Nicolas Lovelean Walton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS					
Yes 1951-1969			213 28 7912			Marine Corps records WASH, D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe peritonitis										53 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) Gunshot wounds of abdomen										53 days	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				330 Jan 18 1969				Shot by another man			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
		Street		203 North Eaden St.		Baltimore				Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				John G. Ball				22b DATE SIGNED			
EXAMINER'S NAME (Type)				John G. BALL, M. D.				13 March 1969			
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Burial				3-17-69		Baltimore National Cemetery Baltimore				Md.	
24 FUNERAL DIRECTOR W. W. Chambers Co.						ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
1400 Chapin Street, N. W. Washington, D.C.								MAR 20 1969		John's Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

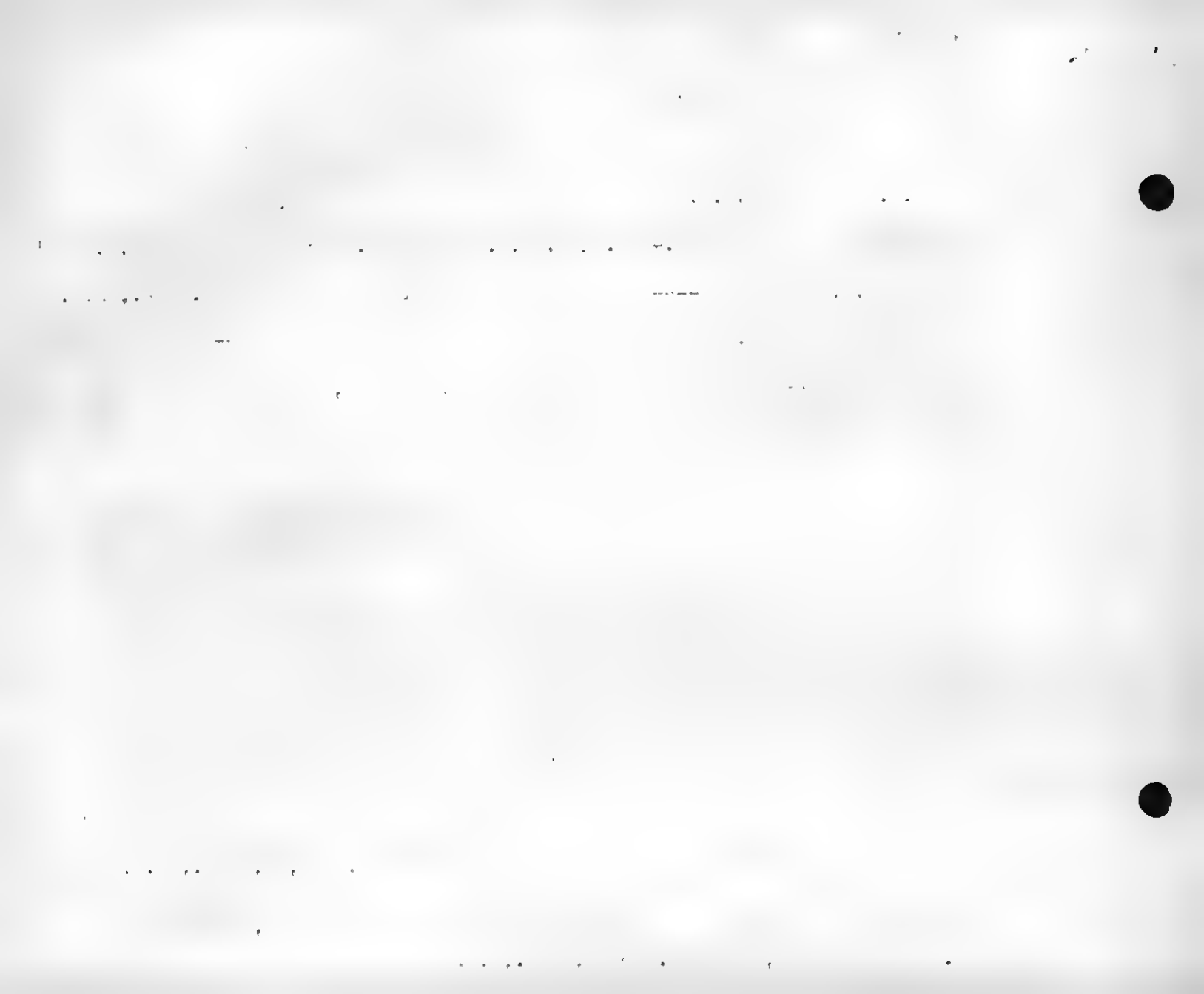
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
Christopher Dane Cassimus						3 Month 25 Day 69 Year			11:55P		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		12-24-90		78 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Canada		Amer. USA				Montgomery Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if ret red)			12b KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington San & Hospital			12a owner			Restaurant		
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13e STREET AND NUMBER				
Maryland			Montgomery		Wheaton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11505 Higby St		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Danny Cassimus			XXXXXX Pearl								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown)			16b SOCIAL SECURITY NO		17 INFORMANT						
Unknown			228-05-0322		Mary L. Cassimus wife XXXXXX XXXXXX 11505 Higby St. S.S. Md						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION - ACUTE MYOCARDIAL INFARCTION											15 MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											6 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
DIABETES MELLITUS. EMPHYSEMA											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from July, 1953, to March 23, 1969, that (I) (we) lost the deceased alive on March 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED		
Robert L. Krichmar									March 26 1969		
22d PHYSICIAN'S NAME (Type)			22e ADDRESS								
ROBERT L. KRICHMAR MD			7733 MASKA AVENUE NW			WASHINGTON DC 20012					
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		March 28, 1969		Parklawn Cemetery		Rockville, Montgomery,				Md.	
24. FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc. Silver Spring, Md.						APR 1 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04038		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04031	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print) CHARLES WESTON CASWELL			2a DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1969</u>		2b HOUR <u>11:30 P.M.</u>		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH 9/19/91		6 AGE (in years last birthday) 77 YRS.	
7a BIRTHPLACE (State or foreign country) N.Y.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Beth.-Sil. Spr. N.H.		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Asst. Director ICC		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY ----		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 4201 Mass. Ave., N.W.		14 FATHER'S NAME First Middle Last Edward R. Caswell		15 MOTHER'S MAIDEN NAME First Middle Last Minnie -- Weston			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) No (If yes give war or dates of service) ----		16b. SOCIAL SECURITY NO. 578-50-8270A		17. INFORMANT Address John F. Caswell, Same as # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio-Sclerotic Cardio-Vascular Disease</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 weeks</u> <u>3 years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 17, 1969</u> , to <u>March 17, 1969</u> , that (I) (we) saw the deceased alive on <u>March 17, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Samuel Diener, MD</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>3/17/69</u>	
22d. PHYSICIAN'S NAME (Type) Samuel Diener				22e. ADDRESS 4201 Mass. Ave, NW, Wash., D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial/Transit		23b. DATE 3/22/69		23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		23d. LOCATION (City or Town) (County) (State) Troy, New York	
24. FUNERAL DIRECTOR Jos. Gawler's Sons, 5130 Wis. Ave, NW, Wash., D.C.				25a. REC'D BY REGISTRAR MAR 20 1969		25b. REGISTRAR'S SIGNATURE <u>William J. Gaudet</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04039

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04032

Item 6 Film 410 3/14/69 kk

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <u>Rossy</u>			First <u>B.</u> Middle <u>CAVE</u> Last			2a. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1969</u>			2b. HOUR <u>4:30 PM</u>								
3 SEX <u>F</u>			4. RACE <u>Cau</u>			5. DATE OF BIRTH <u>Jan 30, 1885</u>			6. AGE (In years last birthday) <u>83</u> YRS.			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Mont.</u>						Md		
10. CITY OR TOWN OF DEATH <u>Kensington, Md.</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Kensington Gardens N.H.</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u>			13b. COUNTY <u>Glen Echo</u>			13c. CITY OR TOWN <u>Glen Echo</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <u>25 Wellesley Circle</u>					
14. FATHER'S NAME First <u>George</u> Middle <u>Fredrick</u> Last <u>Fifer</u>			15. MOTHER'S MAIDEN NAME First <u>MARY</u> Middle <u>Elizabeth</u> Last <u>Burnett</u>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>Yes, no, or unknown</u>			16b. SOCIAL SECURITY NO. <u>none</u>			17 INFORMANT <u>Robert T. Fifer</u>			Address								
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arteriosclerotic cerebral vessels</u> DUE TO, OR AS A CONSEQUENCE OF <u>4017</u> (b) <u>Diagnose</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diagnose</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>65</u> , to <u>March 6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 2</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>[Signature]</u> M.D. DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>3/6/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>G.F. Kreuzburg</u>			22e. ADDRESS <u>7652 16 - 56 NW Wash DC</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE <u>Mar. 7, 1969</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>			23d. LOCATION (City or Town) (County) (State) <u>Wash. D.C.</u>								
24. FUNERAL DIRECTOR <u>Lee Fun. Home, 300 4th St. N.E., D.C.</u>			ADDRESS			25a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>MAR 10 1969</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>								

CLEARED WITH MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04040

CERTIFICATE OF DEATH

04033

1. DECEASED NAME (Type or print) First <u>Marlene</u> Middle <u>Sandra</u> Last <u>CHARRON</u>			2a. DATE OF DEATH Month <u>MARCH</u> Day <u>29</u> Year <u>1969</u>			2b. HOUR <u>10¹⁵ A.M.</u>	
3. SEX <u>FEMALE</u>		4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH <u>12-20-35</u>		6. AGE (in years lost b. day) <u>33</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>MONTGOMERY</u> Md	
10. CITY OR TOWN OF DEATH <u>TAKOMA PARK</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WASHINGTON SANITARY HOSPITAL</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>ADMINISTRATOR</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>CIBA</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <u>MARYLAND</u>		13b. CITY OR TOWN <u>MONTGOMERY</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <u>3406 HEWITT AVE</u>	
14. FATHER'S NAME First <u>CHARLES</u> Middle <u>POOLER</u> Last <u>XXXXXXXXXX</u>			15. MOTHER'S MAIDEN NAME First <u>JACQUELINE</u> Middle <u>AUGUSTE</u> Last <u>XXXXXXXXXX</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO (If yes give war or dates of service) <u>579-44-7705</u>		17. INFORMANT Address <u>Roderick Charron-3404 Hewitt Ave., S.S., Md.</u> #207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>3/29</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>G. Lennard Gold</u>				22c. DATE SIGNED <u>3/29/69</u>		22d. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 2, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Pr. Geo. Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. RECEIVED BY REGISTRAR <u>APR 3 1969</u>		25c. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04034

1 DECEASED-NAME (Type or Print) JOEWAYNE		First JOSEPH		Last CLARK		2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> 3 Day 15 Year 19 69		2b. HOUR 10:45 P.M.	
3 SEX Male	4 RACE Negro	5 DATE OF BIRTH 5-18-39	6 AGE (in years last birthday) 29 YRS.	7 UNDER YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 3 Day 15 Year 19 69		2d. HOUR 10:45 P.M.	
7a. BIRTHPLACE (State or foreign country) D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. L.S.A. RESIDENCE (Where deceased lived, if institution, give address) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Simpsonville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 305 Freetown Road	
14. FATHER'S NAME First Unknown Middle Unknown Last Unknown				15. MOTHER'S MAIDEN NAME First Elsie Middle Clark Last Clark					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO 217-34-0119		17. INFORMANT Elsie Clark ADDRESS same as above:					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bullet wound of abdominal aorta with exsanguination 965X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Due to, or as a consequence of (c) Due to, or as a consequence of								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 9:40 P.M. 3-15 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased shot during a dispute with another man.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) Beer tavern		21f. LOCATION Street or R.F.D. No. Silver Spring City or Town Montg. County Md. State Md.					
22a. I certify that took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE BELDEN K. KEAPPA		EXAMINER'S NAME (Type) BELDEN K. KEAPPA		M.D. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 3/16/1969	
23a. BURIAL CREMATION, etc. Burial		23b. DATE 3-20-69		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery,		23d. LOCATION (City or Town) Sandy Spring, Md. (County) (State)			
24. FUNERAL DIRECTOR Robert L. Snowden				ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR MAR 21 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT5
45M-1

04042		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04035	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) <i>Evelyn H Clarke</i>			2a. DATE OF DEATH Month <i>March</i> Day <i>7</i> Year <i>1969</i>		2b. HOUR <i>9:00</i>
3 SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>1924/2/1</i>		6. AGE (in years last birthday) <i>45</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Mich</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Shubert Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>R.N.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Mont</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LHM? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>582 College Park</i>
14. FATHER'S NAME First <i>William</i> Middle <i>Zinke</i> Last <i>Zinke</i>			15. MOTHER'S MAIDEN NAME First <i>Grace</i> Middle <i>Armonstrong</i> Last <i>Armonstrong</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>225-34-0872</i>		17. INFORMANT <i>Husband Florence Clarke</i> Address <i>Home as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <i>Intracranial hemorrhage, massive, left hemisphere</i>					<i>7 days</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>451-7</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or RFD. No City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from <i>1956</i> to <i>March 6, 1969</i> , that (1) (we) last saw the deceased alive on <i>March 5, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>G. Bowditch Hunter Jr.</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED <i>March 7, 1969</i>	
22d. PHYSICIAN'S NAME (Type) <i>G. Bowditch Hunter</i>				22e. ADDRESS <i>30 W. Edmondston Drive, Rockville, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3/11/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	
23d. LOCATION (City or Town) <i>Rockville, Maryland</i>		(County) (State)			
24. FUNERAL DIRECTOR <i>Lysen Wheeler Funeral Home Rockville, Md.</i>		25a. REC'D BY REGISTRAR <i>1551 Rock. Pike</i>		25b. REGISTRAR'S SIGNATURE <i>John S. Hunter</i>	
DATE <i>MAR 12 1969</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
04043										
04036										
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
James Earl Clementson						Month 3 Day 26 Year 69		8:20P M		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. FUNERAL - YEAR		
Male		Cau.		12/1/99		69 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				
D.C.		U.S.A.				Montgomery Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda, Md.			Gros. Lane Nursing Home			Clerk-Army Map Service		Govt.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
D.C. MD.			Montgomery		Washington		YES		4316 Locust Lane,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
James H. Clementson			Clara Poor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17 INFORMANT Address					
No			577-03-6439		Mrs. D.C. McNulty, 5909 Sonoma Rd., Beth., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Cerebric</i>								<i>3 1/2 years</i>		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer of Colon's metastasizing to Liver</i>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
Sept 1965			Cancer of Transverse Colon			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from August 10, 1960, to April 24, 1969, that (I) (we) last saw the deceased alive on March 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) (d d) view the body after death										
22b. SIGNATURE						22c. DATE SIGNED				
<i>E. Stuart Lyddane</i>						3/24/69				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
E. Stuart Lyddane						3066 Q St., N.W., Wash., D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			3-29-69		CEDAR HILL CEMETERY		SWITLAND, MD.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert A. DeLoaf						APR 1 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

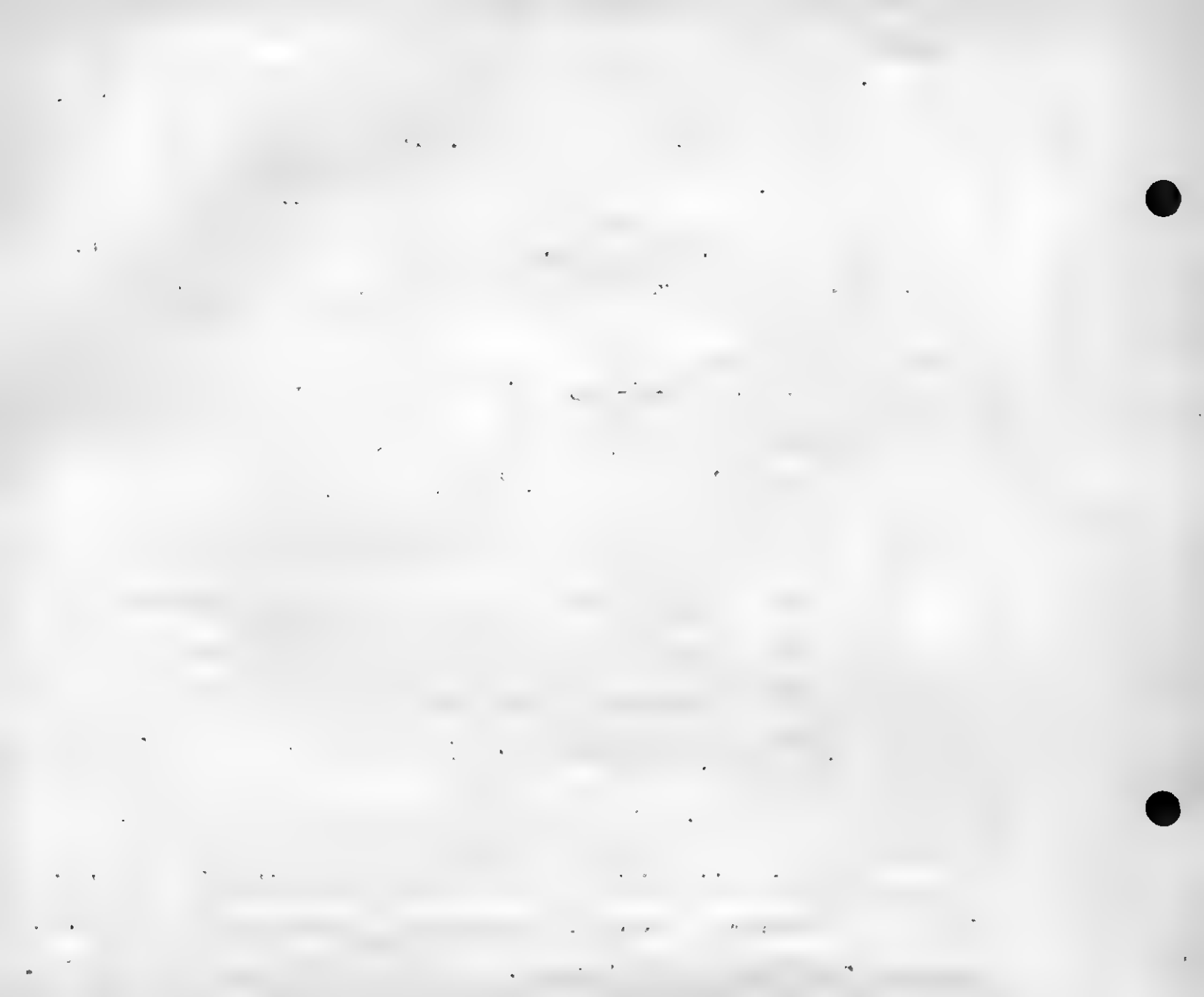
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED-NAME (Type or print) JACOB DAVID COHEN			3. SEX male			4 RACE WHITE			5 DATE OF BIRTH 6/18/96			2a. DATE OF DEATH Month Mar Day 20 Year 1969			2b. HOUR 4:15 MIN PM		
7a. BIRTHPLACE (State or foreign country) Lithuania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			6 AGE (In years last birthday) 72 YRS.			11c. UNDER 1 YEAR MONTHS 12 DAYS 10 HOURS 10 MIN		
10 CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Montgomery CITY OR TOWN Rockville			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First MAX Middle COHEN Last COHEN			15. MOTHER'S MAIDEN NAME First BESSIE Middle COHEN Last COHEN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 013-28-6052			17 INFORMANT DR. SIDNEY J. COHEN Address 11201 GAINSBOROUGH ROAD POTOMAC, MD			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Insufficiency												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4123												DUE TO, OR AS A CONSEQUENCE OF Pulmonary Edema and Pleural Effusion			2 week		
DUE TO, OR AS A CONSEQUENCE OF (c) Marked Coronary Arteriosclerotic heart disease												2 years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. 19 Month 3 Day 5 Year 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No 3/5 City or Town Rockville County Montgomery State MD			22a. I certify that (I) (this hospital) attended the deceased from 3/5/1969 to 3/20/1969 , that (I) (we) last saw the deceased alive on 3/19/1969 , and that in (any) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death								
22b. SIGNATURE Robert C. Macdon			DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 3/20/69											
22d. PHYSICIAN'S NAME (Type) ROBERT C MACON			22e. ADDRESS 809 Hers Mill Rd. - Rockville, MD														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE Mar. 21, 1969			23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden Falls Church, Virginia			23d. LOCATION (City or Town) (County) (State)								
24 FUNERAL DIRECTOR Donald M. Stein			ADDRESS 232 Carroll			25a. REC'D BY REGISTRAR MAR 26 1969			25b. REGISTRAR'S SIGNATURE Hebrew Memorial Funeral Home St., N.W. Wash., D.C.								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		Max First		Middle Harry		Last Cohen		2a. DATE OF DEATH Month 3 Day 11 Year 69		2b. HOUR 1.45p
3. SEX Male		4. RACE White		5. DATE OF BIRTH 6.13.79		6. AGE (In years last birthday) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Lithuania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tailor		12b. KIND OF BUSINESS OR INDUSTRY Clothing				
13a. USUAL RESIDENCE (Where deceased admission) State Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 40b1 Randolph Road		
14. FATHER'S NAME First Jacob		Middle		Last Cohen		15. MOTHER'S MAIDEN NAME First Eva		Middle		Last ?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 577-09-9925		17. INFORMANT Medical Record Dept. Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 1541 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rectal Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rectal Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 1/30, 1967, to 3/11, 1967, that (I) (we) last saw the deceased alive on 3/11, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Alan B. Cohan</u> M.D.		22c. PHYSICIAN'S NAME (Type) Alan B. Cohan. M.D.		22d. ADDRESS 13515 Georgia Ave., Silver Spring, Md.		22e. DATE SIGNED 3/11/67				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-12-1969		23c. NAME OF CEMETERY OR CREMATORY Ohev Sholom Cemetery		23d. LOCATION (City or Town) Washington		(County) D. C.		(State)
24. FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th Street N. W.				25a. REC'D BY REGISTRAR DATE MAR 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04046

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04039

1. DECEASED NAME (Type or Print) Pauline Lucille			First Middle Last Colt			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 4 Year 69			2b. HOUR 10:30		
3 SEX F	4 RACE W	5 DATE OF BIRTH 2-22-04	6 AGE (In years last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 13	IF UNDER 24 HRS HOURS MIN. 	2c. DATE PRONOUNCED DEAD Month 3 Day 4 Year 1969			2d. HOUR 10:30		
7a. BIRTHPLACE (State or foreign country) Burlington, Vermont		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington San & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Red-Curtain			12b. KIND OF BUSINESS OR INDUSTRY Red-Curtain Office		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) Wash. D.C.			13b. COUNTY D.C.			13c. CITY OR TOWN Takoma Park			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Joseph Middle F. Last St. Gertra			15. MOTHER'S MAIDEN NAME First Celia Middle T. Last Gold			13e. STREET AND NUMBER 6610 Eastern Ave. Wash. DC					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO 577-50-1218			17. INFORMANT Mr. Frank J. Colt, 2652 Cory Terrace, Wheaton, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4125 Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus											
19a. DATE OF OPERATION 4/25			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 			21b. TIME OF INJURY Month, Day, Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 			21f. LOCATION Street or R.F.D. No City or Town County State 					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Belden R. Reap			EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED March 4, 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 7, 1969			23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Bladensburg Maryland		
24. FUNERAL DIRECTOR C. Glen Carter			25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge			DATE MAR 10 1969		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04047									
CERTIFICATE OF DEATH									
04040									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Nathan			A. Conn			Month Day Year			5 PM
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
male		white		11-19-84			84 YRS.		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Lithuania		American born				Montgomery Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Takoma Park			Washington Sanitarium - Hospital			Patent Attorney			
13a USLA RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d HS-DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Washington D.C.			D.C.		Washington D.C.		YES		2238 Cathedral Avenue NW
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Isaac Conn			Libby						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT		Address		
No			579-52-3994		Records - Washington Sanitarium - Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>									3 1/2 hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									2 wk
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u>									1 wk
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 23, 1969, to March 13, 1969, that (I) (we) lost saw the deceased alive on March 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE (C. H. Stobbe - M.D.)						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (Type) (C. H. Stobbe - M.D.)						22e ADDRESS 8-312 W. 3rd St. N.W., Wash., D.C.			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial			3/14/69		Cem. of Adas Israel Cong.		Wash., D.C.		
24 FUNERAL DIRECTOR						25a REC'D BY REG. STRAR		25b REGISTRAR'S SIGNATURE	
Bernard Danzansky & Sons						301 14th St. N.W., Wash., DC		MAR 17 1969	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with forms PM-5, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04048

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04041

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH				2b HOUR			
Joseph Thompson Connolly						<input checked="" type="checkbox"/> Month Day Year Mar 17 69				<input type="checkbox"/> Month Day Year Mar 17 1969			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD				2d HOUR			
Male	White	Nov. 12, 1902	66 YRS	4 MONTHS	6 DAYS	Month Day Year March 17 1969				Month Day Year March 17 1969			
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Canada			U.S.A.						Montgomery Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Silver Spring			Bethesda-Silver Spr. Nursing Home			Ret. U.S. Treasury Dept.							
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b COUNTY			13c INSIDE CITY LIMITS?			13e STREET AND NUMBER				
Maryland			Montgomery			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Highland House, Bethesda, Md				
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME										
Charles Connolly			Tina Fleming										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS				
No			none			Charles J. Connolly,			Silver Spring, Md. 632 Whittingham Drive				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure												Weeks	
4 x 4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Years	
(b) Cardiovascular Disease													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				HOUR A.M. P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				March 17/1969					
John G. Ball				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
				ADDRESS (Street, city, town, or county)									
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)	
Burial				March 20, 1969				Parklawn Cemetery				Rockville, Montgomery, Md.	
24 FUNERAL DIRECTOR				25a REC'D BY REG STRAR				25b REG STRAR'S SIGNATURE					
P.J. Smith				DATE MAR 24 1969				s/s, J...					
Warner E. Pumphrey, Inc. Silver Spring, Md.													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A	
MARY FLORIDA COPLIN						3 1 69		10:00M	
3. SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
FEMALE	NEGROE		1/22/89			80 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		UNITED STATES				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
OLNEY			MONTGOMERY GENERAL						
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
STATE MARYLAND		MONTGOMERY		LAYTONSVILLE				RT. 1, Box 139	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
ROBERT						BERTHA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
NO									
18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (d))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a)									6 mo
41: DUE TO, OR AS A CONSEQUENCE OF									1/15
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2/28/69 to 3/1/69, that (I) (we) lost saw the deceased alive on 3/1/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
C. H. H. M.				3/1/69					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		MAR. 4, 1969		BROCKE GROVE CEM.		LAYTONSVILLE, MONTG. MD.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert L. Snowden Rockville Md.				MAR 4 1969		Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04050		CERTIFICATE OF DEATH				04043			
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Elmer F Corridon						March 4 1969			6:24 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years lost birth)		7. UNDER 1 YEAR		8. UNDER 24 HRS.
M	W	8-21-90			18		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Wash DC		USA				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Suburban						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		505 DARTMOUTH AVE
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
James F Corridon						Weniged			Keeley
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
No			577-10-7564		Wife - Mrs Margaret Sartorius		Same as above		
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema & Bronchopneumonia									
551.3 DUE TO, OR AS A CONSEQUENCE OF (b) Gastric ulcer with perforation & Esophageal ulcer									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Acute Hernia									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (th s hospital) attended the deceased from 1955 to 4 month 1969, that (I) (we) last saw the deceased alive on 3 month 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William D. Auld						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4 March '69	
22d. PHYSICIAN'S NAME (Type) WILLIAM D. AULD						22e. ADDRESS SILVER SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			3-7-69		Mt Christ Cemetery		Washington DC		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Collins 500 Union Blvd. W. Silver Spring, Md.						DATE MAR 10 1969		Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04051		CERTIFICATE OF DEATH						04044		
1 DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR M	
George W. Courtney						March 8 1969			2:30	
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)	IF UNDER YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS MIN	
MALE	White		Jan 3 - 1882			87 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New York, N.Y.		U.S.A.				MONTGOMERY Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville			Potomac Valley Mrs. Home							
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
New York			131		YONKERS		25 Livingston Ave			
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
Robert Courtney						Sarah Laughlin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (no, or unknown)			(if yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT		Address
						075-09-3289A		Son - Geo Courtney		1006 Kenna Court Rockville
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic heart disease</u>									years	
41 - DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) _____ DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Uremia secondary to benign prostatic hypertrophy</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 22, 1969</u> to <u>March 8, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 4, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <u>Bouditch Hunter, Jr.</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>March 8, 1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>Bouditch Hunter, Jr.</u>					22e. ADDRESS <u>50 W. Edmonston Dr., Rockville, Md.</u>					
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)	
Burial-transit		3/11/69		Mt. Hope		Yonkers, New York				
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home - 1331 Rockville Pike</u>					25a. REC'D BY REGISTRAR <u>Philip M. ...</u>		25b. REGISTRAR'S SIGNATURE <u>William ...</u>			
<u>Tyson and Wheeler Rockville Md</u>					DATE <u>MAR 12 1969</u>					

174130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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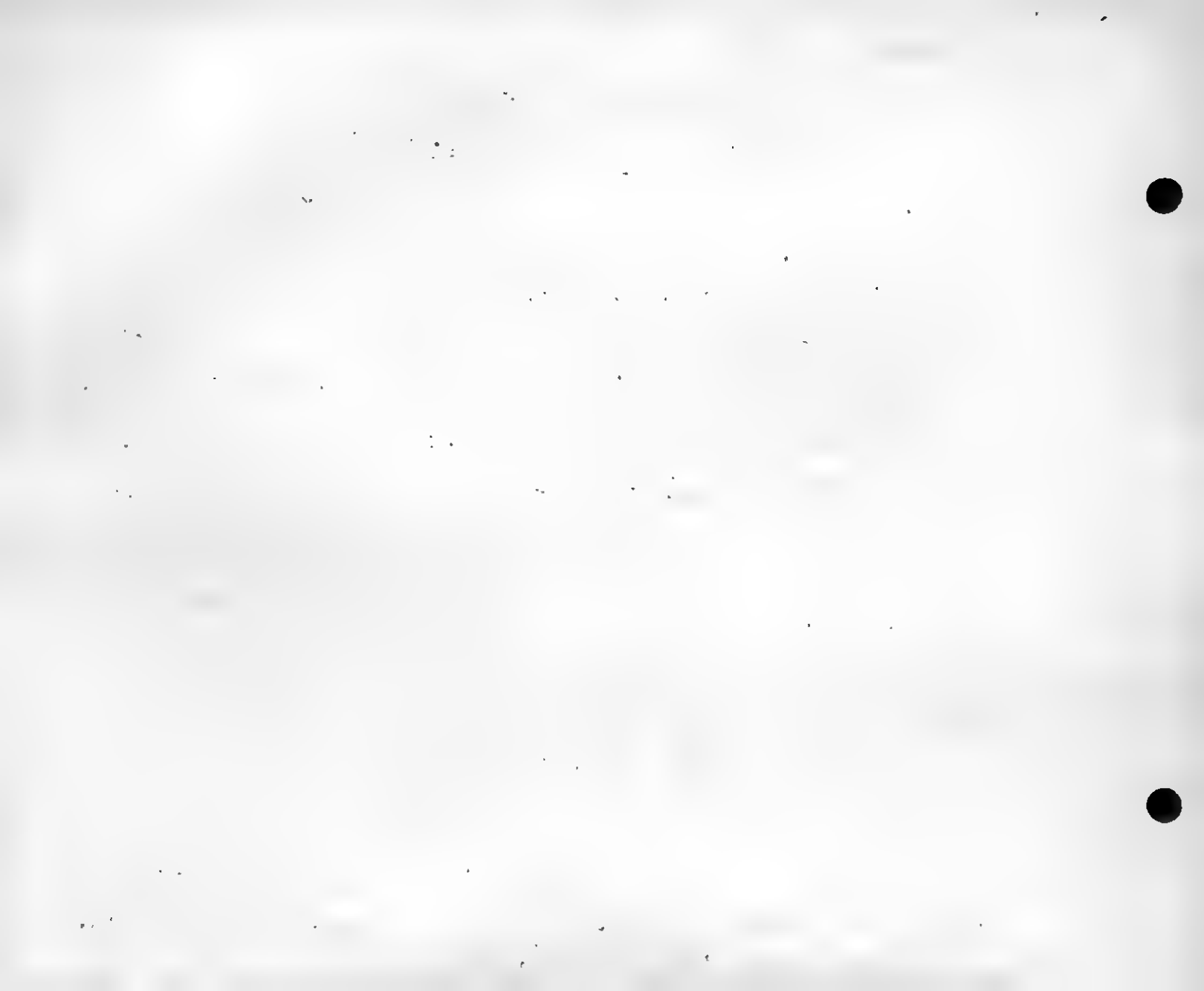
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04052

CERTIFICATE OF DEATH

04045

1. DECEASED NAME (Type or print) MICHAEL P COVICH			2a. DATE OF DEATH Month 3 Day 8 Year 69			2b. HOUR 5⁰⁰ AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3/15/65		6. AGE (In years last birthday) 3 YRS.	
7a. BIRTHPLACE (State or foreign country) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CHILD		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3RD GRANDIN							
14. FATHER'S NAME First Philip P Michael Middle Corich Last COVICH			15. MOTHER'S MAIDEN NAME First Judith Middle Rosamilia Last COVICH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO None		17. INFORMANT Father		Address Same as item # 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY 742 X IMMEDIATE CAUSE (a) Acute, purulent meningitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hydrocephalus DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days 3 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 3-4-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hydrocephalus		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5- , 1965, to 3-8 , 1969, that (I) (we) lost saw the deceased alive on 3-7 , 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Allen B. Coleman, M.D.		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-8-69	
22d. PHYSICIAN'S NAME (Type) Allen B. Coleman, M.D.		22e. ADDRESS 1605 N. Potomac Dr. NW. Wash. D.C. 20012					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/10/1969		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rockville Pike		25a. REC'D BY REGISTRAR 12 1969		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
04053 Cox James										
04046										
1 DECEASED NAME (Type or print)			2a DATE OF DEATH			2b HOUR				
First Middle Last James M Cox			Month Day Year March 16 69			10 13 PM				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR		
M		W		May 3 1897		71 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Miss		USA				Montgomery Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Rockville			Gros Vnor Nursing Home			Fireman				
13a USLA RESIDENCE (Where deceased admission) STATE			13b IF INSTITUTION RESIDENCE BEFORE admission COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
DC			✓		Washington		YES		5814 Sherrier Pl	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
John Cox			Ann Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year and dates of service)			16b SOCIAL SECURITY NO.		17 INFORMANT Address					
Yes			W		Aileen K Cox					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>									Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									4 months	
(b) <u>Cardiac failure</u>										
(c) <u>Crown artery sclerosis</u>									chronic	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medico examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State		
				318		69		316 69		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/16</u> , 19 <u>69</u> , to <u>3/16</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>David A Morowick</u> , M.D.				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>3/16/69</u>		
22d PHYSICIAN'S NAME (Type)				22e ADDRESS						
David A Morowick MD				3721 Gros Vnor Lane Rockville, Md						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		3-19-69		Culpepper National		Culpepper Virginia				
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>				ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>		25a REC'D BY REGISTRAR DATE <u>MAR 24 1969</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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04054										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04047									
Items #4 & 13c, Film 3411, 4/7/69										CERTIFICATE OF DEATH																			
1 DECEASED NAME (Type or print)			First			Middle			Last			2a DATE OF DEATH			Month			Day			Year			2b HOUR					
Mabel			M.			Cree						3			26			69			4A								
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER YEAR			IF UNDER 24 HRS														
Female			Caucasian			5-23-88			80			MONTHS			DAYS			HOURS			MIN								
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Penna			U.S.A.						Montgomery																				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY																				
Chevy Chase			Bethesda - Silver Spring Washington																										
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER																	
Md			Montgomery			Cheverly			YES			2804 Cheverly Ave																	
14 FATHER'S NAME			First			Middle			Last			5 MOTHER'S MA DEN NAME			First			Middle			Last								
John E			Writer									Caroline			Fogle														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO			17 INFORMANT			Address																				
			220-48-799251			Edna Cole			Cheverly, Md.																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) ASHD & acute MI										2 wks																			
4109																													
DUE TO, OR AS A CONSEQUENCE OF																													
(b) Corb arteriosclerosis										2 yrs																			
DUE TO, OR AS A CONSEQUENCE OF																													
(c) Acute Bacterial endocarditis & anemia										9 mo -																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
Anemia ? etiology																													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
			HOUR A.M. Month Day Year P.M. 19																										
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No			City or Town			County														
22a. I certify that (I) (this hospital) attended the deceased from 9-20, 1968, to 3-26, 1969, that (I) (we) last saw the deceased alive on 3/17, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																													
22b SIGNATURE			22c. DATE SIGNED																										
Robert L Flynn MD			3/26/69																										
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS																										
ROBERT L FLYNN MD			916 19th St NW Wash DC																										
23a BURIAL, CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County)			(State)														
Burial			Mar 28, 1969			Glenwood Cemetery			Washington D. C.																				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE																				
P. Gasch's Sons			Hyattsville, Md.			MAR 28 1969			P. Charles Judge																				

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
<div>04055</div> <div>CERTIFICATE OF DEATH</div> <div>04048</div>													
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH		2b HOUR		
James T			Cross		March		10		1969		M		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		WHITE		1-20-96			73 YRS		MONTHS		DAYS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		8 NEVER MARRIED		9 COUNTY OF DEATH					
Wash. D.C.		U.S.A.		WIDOWED		DIVORCED		Montgomery		MD			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
P.O.ville			Frederick Valley Nursing Home			Retired							
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d STREET AND NUMBER				
Md.			Montgomery			Gaithersburg			3 Highland Ave				
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First	
John			Cross		Hilda		Thompson		Mary			Thompson	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address				
Yes			677-09-2612			Hilda K. Cross			3 Highland Ave			Gaithersburg, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												3 MONTHS	
1621 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			HOUR A.M. Month Day Year										
21d INJURY OCCURRED			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION			City or Town				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No			County				
22a I certify that (I) (this hospital) attended the deceased from MAR 6, 1969, to MARCH 10, 1969, that (I) (we) last saw the deceased alive on MAR 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE												22c DATE SIGNED	
Robert C. Daddario													
22a PHYSICIAN'S NAME (Type)												22e ADDRESS	
ROBERT C. DADDARIO												5413 CEDAR LANE BETHESDA MD	
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town)				
Burial			3-12-69			Parklawn			Bethesda				
24 FUNERAL DIRECTOR			25a REC'D BY REG STRAR			25b REC'D BY REG STRAR'S SIGNATURE							
GARTNER			MAR 13 1969			Charles Judge							



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04056									
04049									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR	
Albert			GEORGE Dabbs			March 5 1969		3:30 PM	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 24 HRS	
MALE		WHITE		2-24-1899		72 YRS		MONTHS 8 DAYS 11 HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
England		USA				Montgomery			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban		Kitchen		Stones			
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d INS DE CITY, CHM 157 YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
md		Montgomery		Kensington				3515 ANDERSON RD.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Albert Edward Dabbs			Hannah TENNICK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT		3515 Kensington Rd		
No			213-05-2730-7		Mrs. Elsie C. Dabbs				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u>									4 wks.
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause									
(b) <u>Auricular Fibrillation</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Arteriosclerotic Heart Disease</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 25, 1969, to March 5, 1969, that (I) saw the deceased alive on March 4, 1969, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
Robert T. Thibadeau							March 5 1969		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					11,000 Old Georgetown Road Rockville, Maryland 20852				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
		March 8, 1969		St. Lincoln Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
E. P. Phreay, Inc. Silver Spring, Md.					DATE MAR 12 1969		J. Charles Judge		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A150
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04050	
04057										04050	
1 DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Aileen Gertrude Dalkin						March 17 1969			12:05A M		
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (in years lost birthday)		7. UNDER 1 YEAR		
Female		Caucasian		Nov. 30, 1887			81 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Virginia		USA				Montgomery County Md					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring		9110 Providence Avenue				Homemaker			own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, OR 1ST YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Montgomery		Silver Spring				9110 Providence Avenue			
14. FATHER'S NAME First Middle Lost				15. MOTHER'S MAIDEN NAME First Middle Lost							
William Robert Sanders				Anna Rogers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT		College Park, Md.					
No		213-50-0997		Doris D. Stamp		9727 51st Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis										3 yrs.	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Generalized atherosclerosis										20 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (the hospital) attended the deceased from Jan. 24, 1968, to March 17, 1969, that (I) (we) saw the deceased alive on March 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)			
William B. Gunther, M.D.				March 17, 1969				William B. Gunther, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		23e. REGISTRAR'S SIGNATURE			
Burial		March 19, 1969		Cedar Hill Cemetery		Suitland, Maryland		Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE					
		MAR 20 1969		MAR 20 1969							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04055									
04051									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Robert T			J.		Dannemiller	3 17 69			10 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		White		JUNE 4-84		84 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
OHIO		USA				Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Wheaton			Randolph Hills Nursing Home			Merchandise Broker			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
MD.			MONT.			Rockville		YES	11101 Waycroft Way
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
AGUSTUS			Dannemiller			Julia Phierry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give unit or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address	
No			unknown			Wife Mrs ADA B. Dannemiller		Rockville 11101 Waycroft Way	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Coronary heart failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>arteriosclerotic heart disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
3 mos									
20 yrs.									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/13, 1968, to 3/15, 1969, that (I) (we) last saw the deceased alive on 3/15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
H F Kreuzburg MD			7852 16th NW			Washington DC			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			3-20-69		St. John's Cemetery		Canton, Ohio		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY, Bethesda, Maryland						MAR 24 1969		James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
304 REV 1-66

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) HANNAH			First D. Middle DAVIS			Last			2a. DATE OF DEATH March Month 17 Day 1969			2b. HOUR AM
3. SEX Female		4 RACE White		5 DATE OF BIRTH Sept. 7, 1870			6. AGE (In years lost birthday) 98 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md						
10 CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cedar Haven			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Allegany		13c CITY OR TOWN Midland		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First John Middle Boor Last			15. MOTHER'S MAIDEN NAME First Delilah Middle Baker Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b SOCIAL SECURITY NO. none		17 INFORMANT Address Mrs. Irene Hardaway, Bethesda, Md. 20014							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arthritis and arterial hypertension 715 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Age DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Indefinite												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Mar. 16, 1969 , to Mar. 17, 1969 , that (I) (we) last saw the deceased alive on Mar. 16, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE C. B. Little MD			DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Mar. 17, 1969	
22d. PHYSICIAN'S NAME (Type) A.B. Little			22e. ADDRESS MD 6911 5th St NW Washington, DC									
23a BURIAL, CREMAT. REMOVAL (Specify) Burial		23b. DATE Mar. 20, 1969		23c. NAME OF CEMETERY OR CREMATORY Frb. Memorial Park			23d. LOCATION (City or Town) (County) (State) Frostburg, Md.					
24 FUNERAL DIRECTOR Joseph R. Durst, Sr., Frostburg, Md. 21532			ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 24 1969		25b. REGISTRAR'S SIGNATURE X					

MEDICAL CERTIFICATION

2

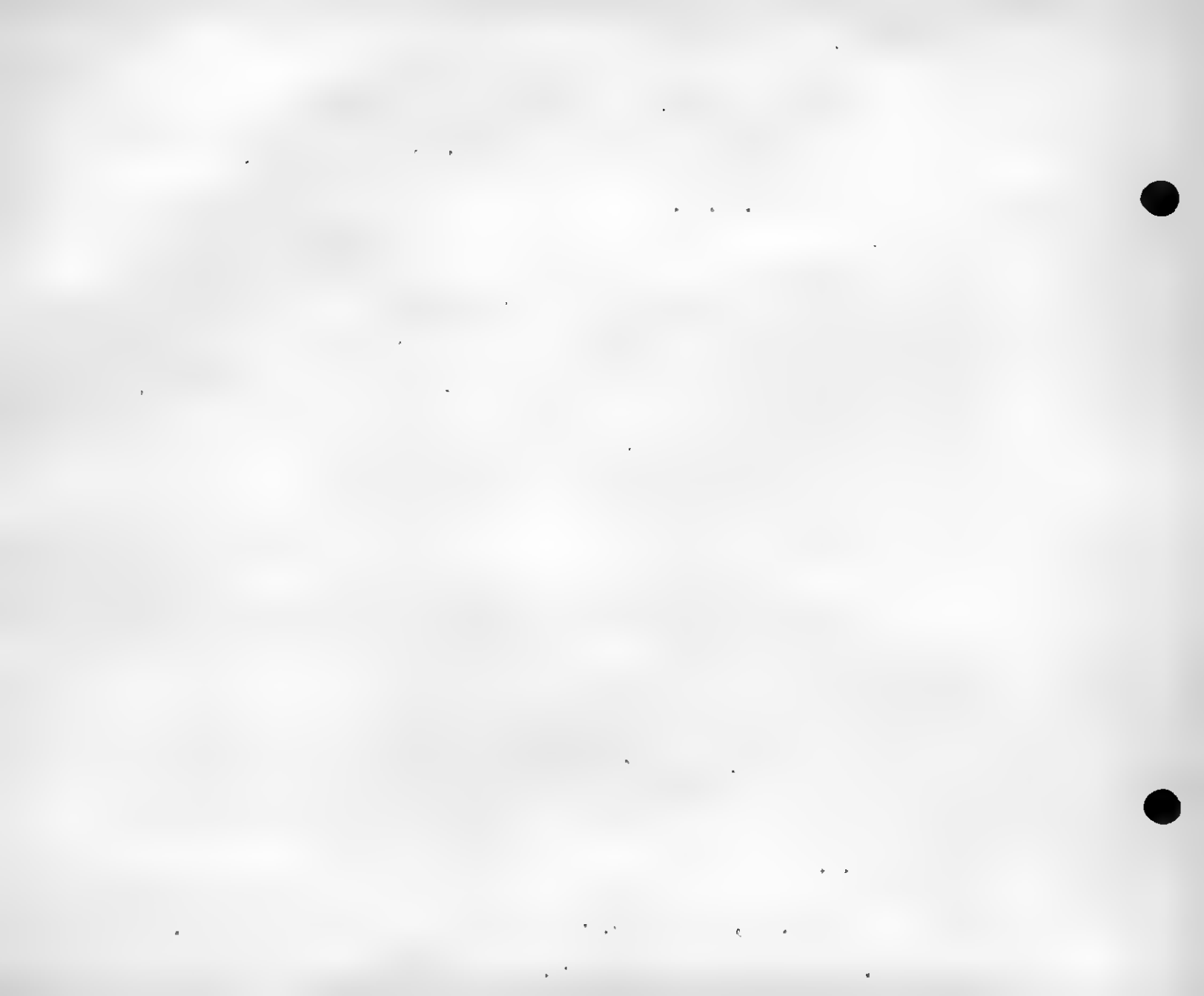
1

04059

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04052



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY FILM 11										05588	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
Robert		William		DECKER				Month Day Year		4 30 69	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
Male	Cau	June 14, 1947	21 YRS	MONTHS DAYS		HOURS MIN		Month Day Year		4 10 69	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH					
Indiana		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Bethesda		Bethesda Naval Hospital		USN							
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
MARYLAND		1		CHEVERLY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5504 Newton Apt #11			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
Wayne		Loyal		DECKER				Marjorie		Lavon Boze	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		WIFE		ADDRESS			
Yes		(If yes give war or dates of service)		364 48 9050		LINDA M. G. DECKER		21 E. No SUMMIT ST		XPSILANTI MICH	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE <u>Asphyxiation due to drowning</u>											
x300 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2 a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 18)		Potomac River					
		4:30 PM Mar. 29 1969		Decased drowned when boat capsized in /							
2 d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory office building, etc)		2 f. LOCATION Street or R.F.D. No		City or Town		County		State	
		Potomac River near Brickyard Road,		Potomac, Montgomery		Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Belden REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)		Belden REAP, M.D.		ADDRESS (Street, city, town, or county)						11 April 1969	
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Cremation		4-12-69		Fort Lincoln Crematory		Washington				D.C.	
24 FUNERAL DIRECTOR W. W. Chambers Co.				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
1400 Chapin St., N.W. Washington, D.C.						APR 18 1969		J Charles Judge			



04061

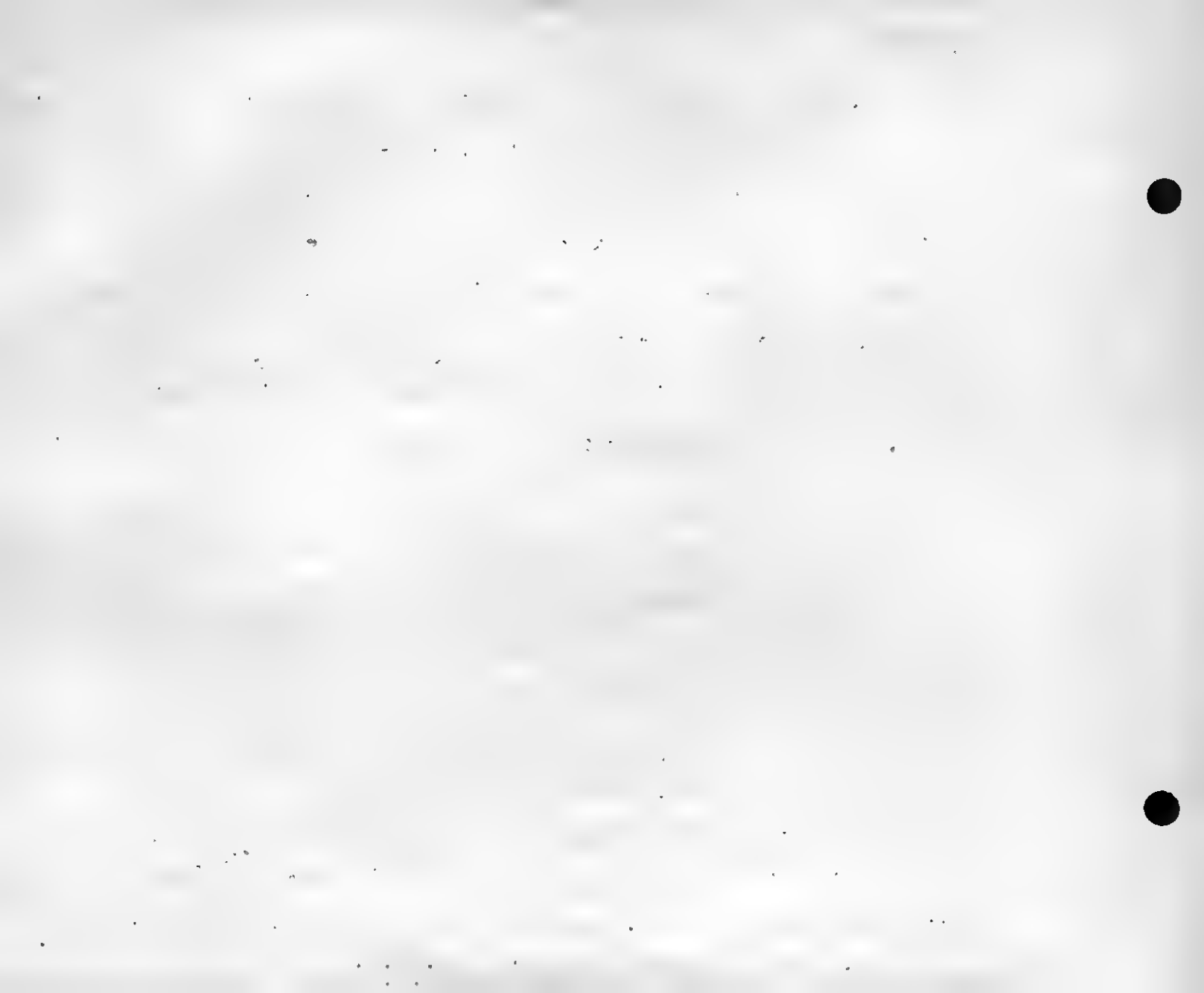
CERTIFICATE OF DEATH

04053

1 DECEASED-NAME (Type or print) Michael Clay DeMerrell			2a. DATE OF DEATH Month March Day 10 Year 1969			2b. HOUR 10:00	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 17 April 1966		6. AGE (In years last birthday) 2 YRS.	
7a. BIRTHPLACE (State or foreign country) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia COUNTY Norfolk		13b. CITY OR TOWN Alexandria		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7131 Richmond Highway	
14. FATHER'S NAME First George Middle Stephan Last DeMerrell			15. MOTHER'S MAIDEN NAME First Patricia Middle Clay				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Neuroblastoma 1925 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 31 Dec. , 19 68 , to 10 March , 19 69 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 10 March , 19 69 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE John S. Sargent, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10 March 1969	
22d. PHYSICIAN'S NAME (Type) John S. Sargent, M. D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION REMOVAL (Specify) cremation		23b. DATE 3/11/69		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Prince Georges County Md.	
24. FUNERAL DIRECTOR The S.H. Hines Company		ADDRESS 2901 14th St.		25a. REC'D BY REGISTRAR N.M.A. 13 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15
45M

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) <i>Infant</i> <i>Wenhaw</i>						2a. DATE OF DEATH Month <i>3</i> Day <i>8</i> Year <i>69</i>			2b. HOUR <i>2:30</i> M				
3 SEX <i>male</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>3/8/69</i>			6 AGE (In years last birthday) YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.							
10 CITY OR TOWN OF DEATH <i>Bethesda</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>16 Manchester Place</i>			
14 FATHER'S NAME First Middle Last <i>Robert Wenhaw</i>						15. MOTHER'S MAIDEN NAME First Middle Last <i>Christine C. Longin</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>-</i>		17 INFORMANT <i>Mother</i>			Address <i>same</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))													
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Maternal separation of placenta & umbilical cord</i>													
7101 DUE TO, OR AS A CONSEQUENCE OF <i>Immaturity</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>John J. Kuhn</i>								DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>11 March 1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>John J. Kuhn</i>				22e. ADDRESS <i>4405 E. West Noddy</i>									
23a. BURIAL (CREMATION) REMOVAL (Specify)				23b. DATE <i>3/11/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Suburban Hospital</i>				23d. LOCATION (City or Town) (County) (State) <i>Bethesda - Montgomery - Md.</i>			
24. FUNERAL DIRECTOR <i>Mrs. Amelia C. Carter</i>				ADDRESS <i>Administrator</i>				25a. REC'D BY REGISTRAR DATE <i>13 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04063 CERTIFICATE OF DEATH 04055									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Alice Loretta DeSpain						Month 3 Day 5 Year 69			8 AM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		white		9-14-79		89 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Iowa		USA				Montgomery Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Tahoma Park			Washington Sanitarium Hospital						
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INS DE CITY, COUNTIES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			Montgomery		Rockville		YES		6141 Tuckerman Lane
14 FATHER'S NAME			15 MOTHER'S M A DEN NAME						
First Middle Last			First Middle Last						
Isaac Armstrong			Maria McCallister						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT		Address		
			219-54-9288		Records - Washington San + Hosp. In				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident									5 weeks
4364 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (b) Oxytocin poisoning									Years
stating the underlying cause (c) Acute Myocardial Process									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Uremia									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? Refused YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from 3-3, 1969, to 3-5, 1969, that (I) (we) lost saw the deceased alive on 3-5-69-19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b SIGNATURE John L. Ford MD					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 3-5-69		
22d PHYSICIAN'S NAME (Type) JOHN L. FORD					22e ADDRESS 871 UNIVERSITY BLVD SILVER SPRING, MD				
23a BURIAL, CREMATION, REBURY (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		3/7/69		Pilot Grove		Williamsburg, Iowa			
24a FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1551 Rock Pike Rockville, Maryland					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE Charles Judge		
					MAR 11 1969				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04064

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04056

1 DECEASED NAME (Type or print) <i>Leage Russell Devine</i>			2a. DATE OF DEATH 3 Month 28 Day 69 Year			2b. HOUR 6 ⁵⁹ / _{PM}			
3. SEX <i>Male</i>		4 RACE <i>Caus.</i>		5 DATE OF BIRTH <i>5-25-1900</i>		6 AGE (In years lost birthday) <i>68</i> YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery County</i> Md			
10. CITY OR TOWN OF DEATH <i>Wheaton, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Queen Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Painter</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>WASH. DC</i>		13c. CITY OR TOWN <i>WASH. DC</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1126 11th St. N.W. Wash. D.C.</i>	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO <i>579-03-9458</i>		17 INFORMANT <i>MRS. DEVINE</i>		Address <i>1126 11th St. N.W. WASH. D.C.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Sepsis secondary to multiple</i> <i>7-75</i> DUE TO OR AS A CONSEQUENCE OF <i>Ulcer</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Poisoning</i>									
19a. DATE OF OPERATION <i>3/28/69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>2/13/69</i> to <i>3/28/69</i> , that (I) (we) last saw the deceased alive on <i>3/28/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Myron J. Lenkin</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>3/28/69</i>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3-31-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Landover Md</i>			
24. FUNERAL DIRECTOR <i>Kallins Funeral Home Inc. 4339 Hunt</i>				ADDRESS		25a. REC'D BY REGISTRAR <i>APR 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1-69

04065										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04057																																							
Item #5, Film G111 4/7/69 km										CERTIFICATE OF DEATH																																																	
1 DECEASED NAME (Type or print) <i>Benjah Catherine DeWane</i>										2a. DATE OF DEATH Month <i>March</i> Day <i>26</i> Year <i>1969</i>										2b. HOUR <i>4:20</i> M																																							
3 SEX <i>female</i>										4 RACE <i>white</i>										5 DATE OF BIRTH <i>7-21-1911</i>										6 AGE (in years last birthday) <i>58</i> YRS										7- UNDER 1 YEAR MONTHS DAYS HOURS MIN										8- UNDER 24 HRS HOURS MIN									
7a BIRTHPLACE (State or foreign country) <i>Wisconsin</i>										7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH <i>Montgomery</i>										Md.																			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>										11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>										12a USAL OCCUPATION (kind of work done during most of work life even if retired)										12b KIND OF BUSINESS OR INDUSTRY <i>Secretary</i>										Md.																			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>										13b COUNTY <i>Montgomery</i>										13c CITY OR TOWN <i>Cherry Chase</i>										13d INSIDE CITY LIM. TSP YES <input type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER <i>3704 - Stewart St.</i>																			
14 FATHER'S NAME First <i>UNKNOWN</i> Middle <i></i> Last <i></i>										15 MOTHER'S MAIDEN NAME First <i>Pearl</i> Middle <i></i> Last <i>Paige</i>																																																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>										16b SOCIAL SECURITY NO. <i>578-22-6887</i>										17 INFORMANT <i>Harold J. DeWane</i>										Address <i>5800 - 1st St.</i>																													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>myocardial infarction</i>										DUE TO, OR AS A CONSEQUENCE OF (b) <i>coronary artery disease</i>										DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>																																																											
19a DATE OF OPERATION <i>None</i>										19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <i>4/10, 1969</i> , to <i>present</i> , that (I) (we) saw the deceased alive on <i>3/27, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death																																																											
22b SIGNATURE <i>John B. Umphrey</i>										DEGREE <i>MD</i>										ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c DATE SIGNED <i>3/28/69</i>																													
22d PHYSICIAN'S NAME (Type) <i>JOHN B. UMPHREY</i>										22e ADDRESS <i>8805 Conn. Ave. Chevy Chase, MD</i>																																																	
23a BURIAL OR CREMATION <i>burial</i>										23b DATE <i>4-1-69</i>										23c NAME OF CEMETERY OR CREMATORY <i>Oak Hill Cemetery</i>										23d LOCATION (City or Town) <i>Lake Geneva, Wisconsin</i> (County) (State)																													
24. FUNERAL DIRECTOR <i>Robert A. Umphrey</i>										ADDRESS <i>7557-Wisconsin Ave., Bethesda, Md.</i>										25a BY REGISTRAR <i>APR 3 1969</i>										25b REGISTRAR'S SIGNATURE <i>James Judge</i>																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04066

CERTIFICATE OF DEATH

04058

1. DECEASED-NAME (Type or print) Arthur Beers Dickinson			2a. DATE OF DEATH Month 3 Day 19 Year 69			2b. HOUR 6:45 A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-4-94		6. AGE (In years last birthday) 74 YRS	
7a. BIRTHPLACE (State or foreign country) Conn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 8521 Garland Avenue		14. FATHER'S NAME First Middle Last Edward M. Dickenson		15. MOTHER'S MAIDEN NAME First Middle Last Fanny Beers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) Yes WWI		16b. SOCIAL SECURITY NO. 032-16-4500		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Benign prostatic hyperplasia							
19a. DATE OF OPERATION 18 March 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Retroperic prostatectomy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner) <input type="checkbox"/>		21b. TIME OF INJURY Hour A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 16, 1969 to March 19, 1969 , that (I) (we) last saw the deceased alive on 18 March 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Henry M. Wise, Jr. MD				22c. DATE SIGNED 19 March 69		22d. PHYSICIAN'S NAME (Type) HENRY M WISE, JR.	
22e. ADDRESS 1111 Spring St, Silver Spring							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/24/69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc.		24b. ADDRESS 8434 Georgia Avenue		25a. REC'D BY REGISTRAR MAR 28 1969		25b. REGISTRAR'S SIGNATURE [Signature]	



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04067		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04059	
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	
MARGARET M DIMAIO						Month 3 Day 8 Year 69	2b. HOUR 8:46 AM
3 SEX	4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS HOURS MIN
FEMALE	WHITE		8/2/94		77 YRS		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
BROOKLYN, N.Y.		U.S.A.				MONTGOMERY Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING		WHEATON NURSING HOME		HOUSEWIFE		AT HOME	
13a USUA. RESIDENCE (Where deceased lived, if not in hospital give street address) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, M 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		MONTGOMERY		SILVER SPRING		11317 COLLEGE VIEW, DR.	
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME	
Phillip Karl						Marie Hochmeyer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		70 Address	
NO		158-07-5148A		ARTHUR DIMAIO		90 Address T VERNON AVE IRVINGTON, N.J.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro Vascular Accident							6 HRS
4364 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS							8 YRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
NONE							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med.co. examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		HOUR AM Month Day Year PM 19					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1960, 19 to 3/4, 1969, that (I) (we) last saw the deceased alive on 3/4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		22c DATE SIGNED					
HENRY W. STOUT MD		3/8/69					
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS					
HENRY W STOUT MD		10011 GEORGIA AVE SILVER SPRING MD					
23a BURIAL, CREMATION, RITUAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
BURIAL		3-11-1969		HOLLYWOOD MEMPK CEM		UNION, N.J.	
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
W.W. Chambers Co		1400 Chapin St NW, Wash DC		MAR 12 1969		James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print) <i>VERA</i>			First <i>Montros</i>			Middle <i>Dixon</i>			2a. DATE OF DEATH 3 Month 5 Day 69 Year			2b. HOUR M	
3 SEX <i>Fe</i>		4. RACE <i>Col</i>		5 DATE OF BIRTH 5/2/1893			6. AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		
7a BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>			7b CITIZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Montgomery</i>				
10 CITY OR TOWN OF DEATH <i>Wheaton</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>University Nursing Home</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Maid</i>			12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, admission) STATE <i>D.C.</i>			13b COUNTY <i>D.C.</i>			13c CITY OR TOWN <i>Washington</i>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>711 Rhode Island Ave. NW</i>		
14. FATHER'S NAME <i>Unknown</i>			First <i>Unknown</i>			Middle <i>Unknown</i>			15 MOTHER'S MAIDEN NAME First <i>Unknown</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>			16b SOCIAL SECURITY NO <i>577-68-6903</i>			17 INFORMANT <i>Yvonne Joyner</i>			Address <i>714 - R.I. Ave. N.W. Washington, D.C.</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1 DEATH WAS CAUSED BY.													
IMMEDIATE CAUSE (a) <i>Septicemia</i>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) <i>hypostatic pneumonia</i>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <i>generalized arteriosclerosis</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>decubitus ulcers</i>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f LOCATION Street or R.F.D. No			City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>1/8</i> , 19 <i>69</i> , to <i>3/8</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1/8</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <i>David A. Morawitz MD</i>						22c DATE SIGNED <i>3/10/69</i>			22d PHYSICIAN'S NAME (Type)				
23a BURIAL CREMATION REMOVAL (Specify)			23b DATE <i>3-10-69</i>			23c NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>			23d LOCATION (City or Town) (County) (State) <i>Bladensburg Rd. N.E.</i>				
24 FUNERAL DIRECTOR <i>James D. Perry</i>			25a. REC'D BY REG STRAR DATE <i>MAR 11 1969</i>			25b REG. STRAR'S SIGNATURE <i>Charles Judge</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Meyer</i>			First <i>Meyer</i> Middle <i>Holinsky</i> Last <i>Holinsky</i>			2a. DATE OF DEATH Month <i>3</i> Day <i>25</i> Year <i>69</i>		2b. HOUR <i>5:57 PM</i>	
3. SEX <i>m.</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>Aug. 14-1914</i>		6. AGE (In years last birthday) <i>54 YRS</i>		IF UNDER 1 YEAR MONTHS <i>2</i> DAYS <i>20</i> HOURS <i>20</i> MIN	
7a. BIRTHPLACE (State or foreign country) <i>Iowa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPAT. ON (Kind of work done during most of working life, even, if retired) <i>Chemist Ford & King Chem</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10005 Palmdale Road</i>	
14. FATHER'S NAME First <i>Isaac</i> Middle <i>Holinsky</i> Last <i>Holinsky</i>			15. MOTHER'S MAIDEN NAME First <i>Urb.</i> Middle <i>Urb.</i> Last <i>Urb.</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>WW II Army</i>			
16b. SOC. SEC. NO. <i>356-09-6413</i>			17. INFORMANT <i>Ursel Holinsky</i>			Address <i>same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary arteriosclerosis with thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INT. PERIOD, BETWEEN ONSET AND DEATH <i>4 days</i> <i>4 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>3/25, 1969</i> , to <i>5/25/79 62</i> , that (I) (we) last saw the deceased alive on <i>3/25 19 62</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert R. Montgomery MD</i>					22c. DATE SIGNED <i>3/26/69</i>				
22d. PHYSICIAN'S NAME (Type) <i>ROBERT R. MONTGOMERY</i>					22e. ADDRESS <i>5411 CEDAR LANE BETHESDA, MD.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3-27-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>NATIONAL MEMORIAL PARK</i>		23d. LOCATION (City or Town) (County) (State) <i>FALLS CHURCH VA.</i>			
24. FUNERAL DIRECTOR <i>GOLDSTEIN FINE & HARRIS 4217 9TH ST. N.W.</i>					25a. APR 1 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04062	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Florence		Middle H.		Last Donaldson		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MAR 23 1969		2b HOUR 2:30 PM
3 SEX Female	4 RACE White	5 DATE OF BIRTH 3/16/78	6 AGE (In years last birthday) 91 YRS	H UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month MAR Day 23 Year 1969		2d HOUR 2:30 PM	
7a BIRTHPLACE (State or foreign country) Mass.		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery					
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD			13b COUNTY Mont. Co.			13c CITY OR TOWN Sil. Spg.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 410 Ednor Road	
14. FATHER'S NAME First HANDEL Middle E Last ERTON				15 MOTHER'S MAIDEN NAME First SARAH Middle DEMBORY Last DEMBORY				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			
16b SOCIAL SECURITY NO None				17 INFORMANT (Son)				ADDRESS SILVER SPRING, MD			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Hemorrhagic Nephritis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Intestinal Bleeding - Diverticulosis											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED MARCH 23, 1969	
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b DATE 3-25-1969		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d LOCATION (City or Town) (County) (State) Coleman Manor Md					
24 FUNERAL DIRECTOR W. W. Chambers Co. 1400 Chapin St. N.W. Wash. D.C.				ADDRESS		25a REC'D BY REGISTRAR MAR 28 1969		25b REGISTRAR'S SIGNATURE Richard A. Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) THOMAS JOHN DONOHUE						2a DATE KNOWN OF DEATH EST. <input checked="" type="checkbox"/> Month 3 Day 1 Year 1969			2b HOUR 1:15 M P		
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 1/31/59		6 AGE (In years and birthday) 10 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a BIRTHPLACE (State or foreign country) Angewood New Jersey				7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY			Md.
10. CITY OR TOWN OF DEATH SILVER SPRING				11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address) HOLY CROSS				12a USUAL OCCUPATION (Kind of work done during most of working life, or retired) CHILD		12b KIND OF BUSINESS OR INDUSTRY STUDENT	
13a USLA. RESIDENCE (State or foreign country, if institution, name and address) STATE MARYLAND				13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 8500 16th Street	
14 FATHER'S NAME First JOHN Middle FRANCIS Last DONOHUE				15 MOTHER'S MAIDEN NAME First DORIS Middle GARCIA Last GARCIA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none				16b SOCIAL SECURITY NO none		17 INFORMANT Mr. John Thomas Donohue ADDRESS 8500 16th St. Sil Sp Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus of 4th ventricle, severe,											
DUE TO, OR AS A CONSEQUENCE OF (b) with compression of brain stem											
DUE TO, OR AS A CONSEQUENCE OF (c) 											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State 							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Keap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED March 1, 1969			
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS Warner E. Pumphrey, 900 8434 Ga. Ave. Sil. Sp. Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) burial		23b DATE 3/5/59		23c NAME OF CEMETERY OR CREMATORY Parkland		23d LOCATION (City or Town) (County) (State) Rockville, Maryland					
24 FUNERAL DIRECTOR Warner E. Pumphrey, 900 8434 Ga. Ave. Sil. Sp. Md.				ADDRESS 		25a REC'D BY REGISTRAR MAN DATE 7 1969		25b REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b HOUR
EWEUL			L				Dooley		Month Day Year March 16 1969			11:45 P.M.
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years last birthday)		7 UNDER 24 HRS	
male			white			9/30/1949			84 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			
Miss.			U.S.A.						Montgomery			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, except if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Bethesda			Shirley Hospital			Merchant						
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before address on) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Montgomery			Rockville					1949 Collins Ave. Apt. 31	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Thomas William Dooley			Mollie Simm Davis									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT			Address			
			431-58-9685			Warrilow Tobley			1318 Emily St Kensington, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) Anterior Wall Heart Disease												
DUE TO OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21d INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No			City or Town			
22a. I certify that (I) (this hospital) attended the deceased from Mar 16, 1969, to Mar 16, 1969, that (I) (we) last saw the deceased alive on Mar 16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE			22c DATE SIGNED									
George Sharpe MD			3/17/69									
22d PHYSICIAN'S NAME (Type)			22e ADDRESS									
George Sharpe MD			10400 Conn. Ave. Kensington, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			3-19-69			Parklawn Cemetery			Rockville Mont. Md			
24. REGISTRAR'S NAME (Type)			24b ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
Robert A Pumphrey			7557 Wisconsin Ave Bethesda, Maryland			MAR 24 1969						

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Attended with medical examiner - 1547

04073										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04065									
Item 2a Film 411 4/15/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR														
James					John					Douglas					Month 3 Day 24 Year 69 2:30 AM														
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (In years last birthday)					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
Male					White					2-16-12					57 YRS														
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH					Md.									
Pennsylvania					U.S.A.										Montgomery														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b. KIND OF BUSINESS OR INDUSTRY														
Silver Spring					Holy Cross Hosp.					Sales					Carpets														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Md.					Montgomery					Sil. Spr.										11215 Oakleaf Dr. S.S.Md.									
14. FATHER'S NAME					First Middle Last					15. MOTHER'S MAIDEN NAME					First Middle Last														
John					? Douglas					Katherine					? Dunn														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO					17. INFORMANT					Address														
No					173-09-3288					Mrs. Margaret Colony - 9243 Greenwood La.					Lanham, Md.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction															HOURS.														
4109 DUE TO, OR AS A CONSEQUENCE OF															?														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS																													
(c) DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROSIS															YEARS.														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (th's hospital) attended the deceased from October, 19 67, to March 23, 19 69, that (I) (we) last saw the deceased alive on January 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED																			
Hugo G. Graziani MD, DEGREE										3/24/69																			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
HUGO G. GRAZIANI										10101 GEORGIA AVENUE S.S., MD.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					Mar 28, 1969					St. Josephs					Plemming, N. Y Cayuga County														
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE														
Warner E. Rumphrey Inc. 8434 Silver Spring, Md. P. S. Smith										MAR 28 1969																			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04074		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				04066							
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR							
Sara Louise Douglass								3 27 1969		6 A		M											
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER YEAR		F UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year		2d HOUR			
7e		W		APR 19, 1919		49 YRS		MONTHS		DAYS		HOURS		MIN		March 27 1969		9 A		M			
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH											
OHIO				U.S.A.								Montgomery				Md							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY											
Bethesda				25 Farmington Court																			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS?				13e STREET AND NUMBER							
Maryland				Montgomery				Bethesda				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				25 Farmington Court							
14 FATHER'S NAME				15 MOTHER'S M.A.DEN NAME																			
Clinton C. Hayes				Minnie Delong																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO				17. INFORMANT				ADDRESS											
No				579-05-9095				GEORGETOWN MED. SCH. RECORDS															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) - Gun shot wound of Head -																Sudden							
155X																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																							
DUE TO, OR AS A CONSEQUENCE OF																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?							
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH								21b TIME OF INJURY Month, Day, Year								21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
								6? PM 3/27 1969								Shot Self in mouth 22 cal. Rifle							
21d INJURY OCCURRED								21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)								21f LOCATION Street or RFD No		City or Town		County		State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>								Home								25 Farmington Court		Bethesda		Montgomery, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b DATE SIGNED			
John S. Ball																March 27, 1969							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town)				(County)				(State)			
REMOVAL				3-28-69				GEORGETOWN UNIV. MED SCH.				WASH. D.C.											
24. FUNERAL DIRECTOR				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE															
John S. Ball				APR 1 1969				Wash D.C.															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death).

VR A15 (4)
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
04075		CERTIFICATE OF DEATH						04067			
1. DECEASED-NAME (Type or print)		First BURNS		M'ddle C.		Last DOWNEY		2a. DATE OF DEATH 3 Month 30 Day 69 Year		2b. HOUR 6:57 PM	
3. SEX MALE		4. RACE CAUCASION		5. DATE OF BIRTH 11-16-1881		6. AGE (In years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY				Md	
10. CITY OR TOWN OF DEATH Cherry Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda Silver Spring Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY N/A					
13a. USAL RESIDENCE (Where deceased lived, if instituton- Residence before admission) STATE D.C.		13b. COUNTY V		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4215 BRANDYWINE ST., N.W.			
14. FATHER'S NAME First Middle Last Calvin W. Downey		15. MOTHER'S MAIDEN NAME First Middle Last Laura J. Collins									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 578-62-0020-T		17. INFORMANT Address ROBT. J. DOWNEY - SAME AS #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY 4220 IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1960, 19 to 3/30/69, that (I) (we) saw the deceased alive on 3/24/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles P. Duvall		DEGREE ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3-30-69					
22d. PHYSICIAN'S NAME (Type) CHARLES P. DUVALL		22e. ADDRESS 2141 K ST NW									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/3/69		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.					
24. FUNERAL DIRECTOR S. GAWLER'S FUNERAL HOME		25a. REC'D BY REGISTRAR APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04076

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04068

1. DECEASED NAME (Type or print) First Middle Last <i>Albert DUGGAN</i>			2a. DATE OF DEATH <i>March 22 1969</i> Month Day Year		2b. HOUR <i>12 35</i> AM PM		
3 SEX <i>Male</i>		4 RACE <i>Caucasian</i>		5 DATE OF BIRTH <i>August 1 1883</i> Month Day Year		6 AGE (In years last birthday) <i>85</i> YRS MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>	
10 CITY OR TOWN OF DEATH <i>Silver Spring Maryland</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Colonial 5110 N. Harp. Ave. 1225 New Harp. Ave.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>machinist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>fire dept</i>	
13a. USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>P. G.</i>		13c. CITY OR TOWN <i>Laurel</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <i>unknown</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>unknown</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no or unknown		16b. SOCIAL SECURITY NO	
17. INFORMANT <i>James Duggan Laurel Md</i>		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Congestive Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arterio-sclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>severe generalized arterio-sclerosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 years</i> <i>10 years</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Fracture Right femoral neck (old.)</i>							
19a. DATE OF OPERATION <i>8-20-68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>R. Fr. Femoral neck</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>8 19 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fell in nursing home</i>		21f. LOCATION Street or RFD No City or Town County State <i>Fairland Nursing Home Fairland Nursing Home Silver Spring Md</i>	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>Fairland Nursing Home</i>		21f. LOCATION Street or RFD No City or Town County State <i>Fairland Nursing Home Fairland Nursing Home Silver Spring Md</i>		22a. I certify that (I) (this hospital) attended the deceased from <i>8-10-1968</i> to <i>3-21-1969</i> , that (I) (we) last saw the deceased alive on <i>3-21-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE <i>Herbert S. Gates M.D.</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3-22-69</i>		22d. PHYSICIAN'S NAME (Type) <i>819 E. Cap. St. HERBERT S. GATES M.D.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>3-25-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ST. LAWRENCE CEM</i>		23d. LOCATION (City or Town) (County) (State) <i>CHARLESTON S. CAR</i>	
24. FUNERAL DIRECTOR <i>DONALDSON FUNERAL HOME LAUREL MD</i>		ADDRESS		25a. REGISTRAR'S SIGNATURE <i>APR 1 1969</i>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04077									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) MRS. GERTRUDE			First Middle Last ELKINS			2a. DATE OF DEATH Month Day Year MARCH 9 1969		2b. HOUR 1:15 AM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH JULY 6, 1901		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS M. N.	
7a. BIRTHPLACE (State or foreign country) HUNGARY		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH CHEVY CHASE		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) BETHESDA SILVER SPRING NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY —		13c. CITY OR TOWN WASHINGTON		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4000 MASS. AVE. N.W.	
14. FATHER'S NAME First Middle Last MARTIN MOSKOWITZ			15. MOTHER'S MAIDEN NAME First Middle Last ROSE — —						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) — (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 578-30-4400A		17. INFORMANT Address SAMUEL H. ELKINS, HUSBAND, SAME AS #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Cirrhosis 1511 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Alcohol consumption, 25 m DUE TO, OR AS A CONSEQUENCE OF (c) Cancer metastasis 51m.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute Peritonitis; Hypertension; heart disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Oct 1, 1969 to March 9, 1969 , that (I) (we) last saw the deceased alive on 3-8-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Benjamin Manchester		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) BENJAMIN MANCHESTER		22e. ADDRESS 206 Spring St NW			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-11-1969		23c. NAME OF CEMETERY OR CREMATORY King David Cemetery		23d. LOCATION (City or Town) (County) (State) Falls Church, Fairfax Co., Va.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.,				ADDRESS 5130 Wisc. Ave.		25a. REC'D BY REGISTRAR MAR 14 1969		25b. REGISTRAR'S SIGNATURE John S. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1

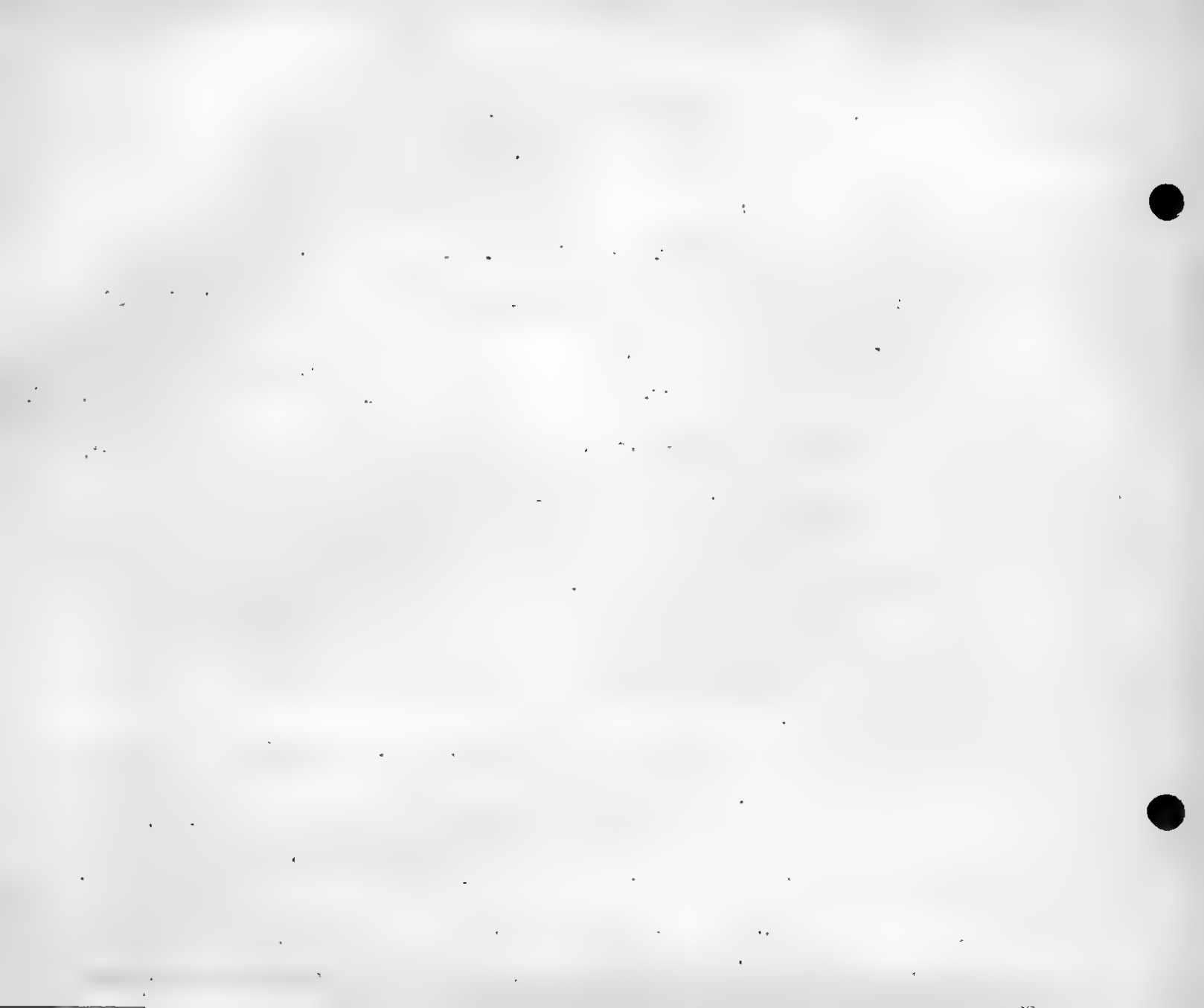
04078

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04070

1. DECEASED NAME (Type or print) First Middle Last Kathy Lynn Erisman			2a. DATE OF DEATH Month Day Year March 19 1969			2b. HOUR A M 2:40 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8 February 1962		6. AGE (In years lost-birthday) 7 YRS.	
7a. BIRTHPLACE (State or foreign country) Connecticut		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address) NIH The Clinical Center		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 12221 Bluhill Road		14. FATHER'S NAME First Middle Last Donald B. Erisman		15. MOTHER'S MAIDEN NAME First Middle Last Judith G. Carter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Records Address The Clinical Center, NIH, Bethesda, Md. 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram-negative septicemia and pneumonia</u> 2040 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute lymphocytic leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 3 5/6 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Meningeal leukemia, seizure disorder, coma of unknown etiology</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <u>6 Jan.</u> , 1969, to <u>19 March</u> , 1969, that (X) (we) lost saw the deceased alive on <u>19 March</u> 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 19 March 1969			
22d. PHYSICIAN'S NAME (Type) Alan L. Snyder, M.D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-24-69		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR Francis J. Collins 500 University Blvd. W. Silver Spring, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE 'R 24 1969		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04079

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04071

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last William Hull EVANS			2a. DATE OF DEATH Month Day Year 3 Month 4 Day 69 year		2b. HOUR 11:50 PM
3 SEX Male	4. RACE Negro	5. DATE OF BIRTH MARCH 6, 1923		6 AGE (In years last birthday) 45 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) Florida	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Drosucor, Inc. Nursing & Conv. Center, 5921 Grosvenor Lane		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Truck driver		12b K'ND OF BUSINESS OR INDUSTRY
13a USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE W.D.C.	13b CITY OR TOWN Washington	13c NO. OF CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 50 Irving Street, NW		
14. FATHER'S NAME First Middle Last Willie EVANS		15 MOTHER'S M'ADEN NAME First Middle Last Bydea Beatrice Holmes			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="radio"/>	(If yes give war or dates of service)	16b SOCIAL SECURITY NO 578-182-503	17 INFORMANT Address Mrs. Bydea ESTICK 3603 10th St. N.W. DC		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) aspiration pneumonia 1419 DUE TO, OR AS A CONSEQUENCE OF carcinoma of the tongue Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 18 mo. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State 2/28 69 to 3/5 69		
22a. I certify that (I) (this hospital) attended the deceased from 2/28 , 19 69 , to 3/5 , 19 69 , that (I) (we) last saw the deceased alive on 3/4 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE David Morowitz		22c. DATE SIGNED 3/5/69		22d PHYSICIAN'S NAME (Type) Dr. David Morowitz	
22e ADDRESS 5721 Grosvenor La. Bethesda, Maryland					
23a BURLIAL <input checked="" type="checkbox"/> OR CREMATION <input type="checkbox"/> (Specify)	23b DATE 3/10/69	23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial	23d LOCATION (City or Town) (County) (State) Suitland PG Md.		
24 FUNERAL DIRECTOR Morrow + Woodford		24b ADDRESS 1622 11th St. N.W. Washington, D.C.	25a REC'D BY REGISTRAR DATE MAR 10 1969	25b REGISTRAR'S SIGNATURE Charles Judge	

04080

CERTIFICATE OF DEATH

04072

1. DECEASED-NAME (Type or print) First Middle Last MICHELLE K. FAGAN			2a. DATE OF DEATH Month Day Year MARCH 24 1969			2b. HOUR 505 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 2/17/69		6. AGE (In years last birthday) MONTHS DAYS HOURS MIN 5 YEARS 1 11 50		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY Beltzville		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 5002 Naples Ave	
14. FATHER'S NAME First Middle Last LEONARD W. FAGAN JR			15. MOTHER'S MAIDEN NAME First Middle Last MARGARET P. RUSSELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. —		17. INFORMANT Leonard W. Fagan Jr			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia								
4. DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral confluent broncho-								
Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACILITY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 3/13/69 , 19__, to 3/24/69 , 19__, that (I) (we) last saw the deceased alive on 3/24/69 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Stanley H. Steinberg, MD.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/24/69		
22d. PHYSICIAN'S NAME (Type) Stanley H. Steinberg				22e. ADDRESS 1040 University Blvd Silver Springs, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar 25, 1969		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Springs Montgomery Md		
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR MAR 27 1969		25b. REGISTRAR'S SIGNATURE F. Gasch, Jr.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released by Med. Exam. Dr. Paul J. ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04081

CERTIFICATE OF DEATH

04073

1. DECEASED NAME (Type or print) MARTHA HENRIETTA FERGUSON			2a. DATE OF DEATH Month Mar. Day 26 Year 1969			2b. HOUR 7^{PM}	
3 SEX Female		4 RACE Cauc.		5 DATE OF BIRTH Dec. 9, 1885		6 AGE (n years lost birthday) 83 YRS	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 13314 Okinawa Ave.		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 13314 Okinawa Ave.		14 FATHER'S NAME First Julius Middle Marinier Last		15 MOTHER'S MAIDEN NAME First Daug. Middle Tucker Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO 545-38-4080A		17 INFORMANT Mrs. Tucker		18 ADDRESS Same as Item 13.		19. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Insufficiency		DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months 4 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of Breast - No evidence of metastasis							
19a. DATE OF OPERATION 11 March 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Proctenteria		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month 19 Day 19 Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6 March, 1969 to 20 March, 1969 , that (I) (we) last saw the deceased alive on 20 March, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Eugene P. Libre		DEGREE EUGENE P. LIBRE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 27 March 69	
22d. PHYSICIAN'S NAME (Type) EUGENE P. LIBRE		22a. ADDRESS 10400 Conn. Ave., XXXXX Kensington, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-3-69		23c. NAME OF CEMETERY OR CREMATORY Brighton Cemetery		23d. LOCATION (City or Town) (County) (State) Brighton, Illinois	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04082

04074

1 DECEASED-NAME (Type or print) VITA			First Middle Last (none) FERRARA			2a. DATE OF DEATH Month Day Year March 6 1969			2b HOUR 6:40 PM		
3 SEX Female			4 RACE White			5. DATE OF BIRTH 7-30-81			6 AGE (In years month day) YRS. 87		
7a BIRTHPLACE (State or foreign country) Italy			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Takoma Park			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY At Home		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b COUNTY Montgomery			13c CITY OR TOWN Silver Spring			13d INSIDE CITY, N.Y.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER 1505 Red Oak Dr.			14. FATHER'S NAME First Middle Last Frank -- DiMisa			15 MOTHER'S MAIDEN NAME First Middle Last Frances -- Spagnuolo					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b SOCIAL SECURITY NO -----			17 INFORMANT Address Mrs. Frances Rogers 1505 Red Oak Dr. S.S., Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema 4122 DUE TO, OR AS A CONSEQUENCE OF: (b) Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Hypertensive & arteriosclerotic CVD									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hr. 2 yrs. 10 yrs.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (this hospital) attended the deceased, from Mrs. , 19 68 , to Mrs. 6 , 19 69 , that (we) lost saw the deceased alive on Mrs. 5 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE R.D. Bauer MD.			DEGREE MD.			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED 3-7-69		
22d. PHYSICIAN'S NAME (Type) R.D. Bauer, MD.			22e ADDRESS 2513 Buck Lodge Rd. Bethesda, Md.								
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE 3/10/69			23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			23d LOCATION (City or Town) (County) (State) Washington, D.C.		
24. FUNERAL DIRECTOR Joe. Gawler's Sons, 5130 Wis. Ave. N.W.						25a. REC'D BY REGISTRAR DATE MAR 14 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.



04083

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04075

FOR STATE
HEALTH DEPT.

| | | | | | | | | |
|---|------------------------|--|--|---|----------------------------------|--|--|---|
| 1 DECEASED NAME
(Type or Print) Mary Ann Flores | | | 2a DATE KNOWN
OF ESTI
DEATH MATED <input checked="" type="checkbox"/> 3-24 69 | | | 2b HOUR
19 8:30 | | |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
3-8-35 | 6 AGE (In years
last birthday)
34 YRS | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS
HOURS
MIN. | 2c. DATE PRONOUNCED DEAD
Month 3 Day 24 Year 69 | | |
| 7a BIRTHPLACE (State or foreign
country) New Mexico | | 7b CITIZEN OF WHAT COUNTRY?
America | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Montgomery | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital
give street address)
Washington San & Hospital | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Analyst | | 12b KIND OF BUSINESS OR
INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before
admission) Maryland | | 13b COUNTY
Lanham | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER
5608 Whitfield Chapel Rd | | |
| 14 FATHER'S NAME First Jose Middle Pablo Last Flores | | | 15 MOTHER'S MAIDEN NAME First Delia | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT
Hosp chart | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive, acute, cerebral hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b) due to Ruptured Berry Aneurysm
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | 20 AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County |
| 22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL
SIGNATURE Belden R. Reap M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b DATE SIGNED | | |
| EXAMINER'S
NAME (Type) BELDEN R. REAP, M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 3/24/1969 | | |
| 23b BIRTH, CREMATION
REMOVAL (Specify) | | | 23b DATE March 24-1969 | | | 23c NAME OF CEMETERY OR CREMATORY
Greenview | | |
| 23d LOCATION (City or Town) | | | County | | | State | | |
| 24. FUNERAL DIRECTOR
John J. Williams | | | ADDRESS
254 Carroll St., N.W. | | | 25a. REC'D BY REGISTRAR
DATE 27 1969 | | |
| 25b REGISTRAR'S SIGNATURE
John J. Williams | | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1 (1-64)
304 REV 1-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|---|---|--|--|---|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| 04084 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 04076 | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Dorothy</i> | | | First <i>H.</i> | | Middle <i>Fluent</i> | | Last | | 2a. DATE OF DEATH
Month <i>March</i> Day <i>3</i> Year <i>1969</i> | | 2b. HOUR
<i>9.05 PM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>April 3, 1898</i> | | | 6. AGE (In years
lost birthday)
<i>70</i> YRS | | F UNDER 1 YEAR
MONTHS <i>11</i> DAYS <i>2</i> | | H UNDER 24 HRS
HOURS <i>11</i> M N. | |
| 7a. BIRTHPLACE (State or foreign
country)
<i>Maine</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Holy Cross of Silver Spring</i> | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
<i>Housewife</i> | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before
admission) STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY L.M.T.S?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>4710 Kemper Street</i> | | | | |
| 14. FATHER'S NAME
<i>Walter</i> | | | First <i>Hall</i> | | Last | | 15. MOTHER'S MAIDEN NAME
<i>Annie</i> | | First <i>Hall</i> | | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
<i>No</i> | | | 16b. SOCIAL SECURITY NO
<i>001-186-6299</i> | | 17. INFORMANT
<i>Mr. Roger E. Bucklin</i> | | Address
<i>4710 Kemper Street, Rockville, Maryland</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Hypertension with extension</i> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (b) <i>into right Atrium</i> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>—</i> , 19 <i>66</i> to <i>3-3</i> , 19 <i>69</i> , that (I) (we) last
saw the deceased alive on <i>3-3</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) <i>(did)</i> (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>G.B. Cushman</i> | | DEGREE | | ATTENDING
PHYS <input checked="" type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3-4-69</i> | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) <i>Gilbert B. Cushman</i> | | 22e. ADDRESS
<i>11161 Ne. Hampshire Ave., Silver Spring</i> | | | | | | | | | | |
| 23a. BURIAL CREMATION
REMOVAL (Specify)
<i>Cremation</i> | | 23b. DATE
<i>March 6, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Vincent's Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Blade Run, Maryland</i> | | | | | | |
| 24. FUNERAL DIRECTOR
<i>Walter E. P. Phyllis, Jr.</i> | | Address
<i>134 Georgia Avenue</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 10 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04085

04077

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHA. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File, pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | | |
|--|---------|---|--------|--|--------------------------|---|-----------------|---|--------------------------|--|
| 1. DECEASED NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | <input checked="" type="checkbox"/> ESTIMATED | Month | Day | Year | 2b. HOUR |
| JOHN BASIL FORBES SR | | | | | 3 | | 21 | 1964 | 10:37 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | 7. UNDER 1 YEAR | | F. UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
| MALE | WHITE | 7/23/21 | | 47 (RS) | MONTHS DAYS | | HOURS MIN | | MARCH 21 | 10:37 AM |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| NEW YORK | | LI SA | | | | MONTGOMERY Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| BETHESDA | | SUBURBAN | | ENGINEER | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS | | 13e. STREET AND NUMBER | | |
| MARYLAND | | MONTGOMERY | | ROCKVILLE | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1604 BRADLEY AVE | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| ROD | | A | | FORBES | ADA | | M | | VAN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | ADDRESS | | | | |
| NAVY | | 11-011 | | 180-12-8174 | | WIFE - WYLLMA B. FORBES (as above) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction old + Recent - | | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | years. |
| (b) Secondary Arteriosclerosis - | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| CAUSE OF DEATH | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State |
| | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | John G. Ball | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | John G Ball | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | March 22, 1969 | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 207936 Old Georgetown | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, OR OTHER | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | |
| Burial | | 3-25-69 | | Baltimore National | | Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Robert A Pumphrey | | | | 7557 Wisconsin Ave Bethesda, Md | | | | MAR 26 1969 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14,
45M - 1/66

| 04086 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04078 | |
|--|--|--|----------------|--|------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1 DECEASED-NAME
(Type or print) <u>AMY</u> | | | First <u>L</u> | | Last <u>FORD</u> | | 2a DATE OF DEATH
Month <u>March</u> Day <u>5</u> Year <u>1969</u> |
| 3 SEX
<u>Female</u> | | 4 RACE
<u>White</u> | | 5 DATE OF BIRTH
<u>2/18/86</u> | | 6 AGE (in years last birthday)
<u>83</u> YRS. | |
| 7a BIRTHPLACE (State or foreign country)
<u>Va.</u> | | 7b CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery</u> | |
| 10 CITY OR TOWN OF DEATH
<u>Bethesda</u> | | NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>Suburban Loop</u> | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Housewife</u> | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>DC</u> | | 13b COUNTY <u>1st</u> | | 13c CITY OR TOWN
<u>Washington</u> | | 13d INS-DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First <u>George</u> Middle <u>Sheen</u> Last <u>Jennie</u> | | 15. MOTHER'S MAIDEN NAME First <u>Jennie</u> Middle <u>Buckley</u> Last <u>N.W.</u> | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address
<u>ELVA H. Tyler - 3254-Washington St N.W.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia, severe</u>
<u>1400</u> DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Nephrosclerosis & renal failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(c) <u>Arteriosclerosis severe & hypertension</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3-4 days?</u>
<u>undet.</u>
<u>3 yrs +</u> | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>St. hemiplegia, severe bulbar & General extensor dermatitis</u> | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | 21f LOCATION Street or RFD No City or Town County State | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Jan. 1969</u> to <u>3-5, 1969</u> , that (I) (we) lost the deceased on <u>3-4-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death | | | | | | | |
| 22b SIGNATURE
<u>Stewart Clapp MD</u> | | 22c DATE SIGNED
<u>March 5 1969</u> | | 22d PHYSICIAN'S NAME (Type)
<u>Stewart Clapp MD</u> | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b DATE
<u>Mar 7-1969</u> | | 23c NAME OF CEMETERY OR CREMATORY
<u>Arlington Natl. Cem.</u> | | 23d LOCATION (City or Town) (County) (State)
<u>Arlington, Virginia</u> | |
| 24. FUNERAL DIRECTOR
<u>Simmons Bros</u> | | ADDRESS
<u>Wash DC</u> | | 25a REC'D BY REGISTRAR
<u>Charles Judge</u> | | 25b REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| 25c ADDRESS
<u>Simmons Bros 1661-Good Hope Rd SE</u> | | | | DATE
<u>MAR 7 1969</u> | | | |

04087

CERTIFICATE OF DEATH

04079

| | | | | | |
|---|--|--|---|---|---|
| 1. DECEASED-NAME
(Type or print) First Middle Last
EL ARD JACKSON FOX | | | 2a. DATE OF DEATH
Month Day Year
March 15 1969 | | 2b. HOUR
8:55 AM |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH
8-31-95 | | 6 AGE (In years last birthday)
73 YRS | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN |
| 7a BIRTHPLACE (State or foreign country)
Virginia | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md | | |
| 10 CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San. & Hospital | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Retired Chemist | | 12b KIND OF BUSINESS OR INDUSTRY
Dept. of Agriculture |
| 13a USUAL RESIDENCE (Where deceased lived, first listed on Residence before admission)
STATE Maryland | 13b COUNTY
Montgomery | 13c CITY OR TOWN
Silver Spring | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER
112 Revere Place | |
| 14 FATHER'S NAME
First Middle Last
William Pierce Fox | | 15 MOTHER'S M A D E N NAME
First Middle Last
Mary Ellen Digges | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b SOCIAL SECURITY NO.
N/A | | 17 INFORMANT
Mrs. Grace Fox 112 Revere Pl., S.S., Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 min
15 yrs |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>Sep 54</u> , to <u>March 15, 1969</u> . That (I) (we) last saw the deceased alive on <u>March 14, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
<u>Russell B. Arnold</u> | | DEGREE | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | 22c DATE SIGNED
<u>3/15/69</u> | |
| 22d PHYSICIAN'S NAME (Type)
<u>Russell B. Arnold MD</u> | | 22e ADDRESS
<u>1106 Spring Street, Silver Spring, Md. 20910</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b DATE
<u>Mar 18, 1969</u> | 23c NAME OF CEMETERY OR CREMATORY
<u>St. Lincoln</u> | | 23d LOCATION (City or Town) (County) (State)
<u>Bladensburg, Md.</u> | |
| 24 FUNERAL DIRECTOR
<u>Warner E. Humphrey Inc. 8434 Ga. Ave. Silver Spring, Md.</u> | | 25a REC'D BY REG STRAR
DATE <u>MAR 20 1969</u> | | 25b REG. STRAR'S SIGNATURE
<u>William C. Under</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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| | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|---|---|--|--|---|--|--|---|---|-------------------------------|--|--|--|--|--|
| Item 18 Film 411 4-7-69 | | | | | | | | | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04088 | | | | | | | | | | 04080 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
Richard Vogeli FOX | | | | | 20. DATE OF DEATH
March Month 25 Day 69 Year | | | | | 2b. HOUR
930A M | | | | | | | | | |
| 3. SEX
Male | | | 4. RACE
Caucasian | | | 5. DATE OF BIRTH
September 18, 1931 | | | 6. AGE (in years last birthday)
37 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Indiana | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
U. S. Navy | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia | | | 13b. COUNTY Fairfax | | | 13c. CITY OR TOWN
Alexandria | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
6315 Landess St. | | | | | | | |
| 14. FATHER'S NAME First Guy Middle K. Last FOX | | | | | 15. MOTHER'S MAIDEN NAME First Helen Middle Vogeli Last Vogeli | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown Yes (If yes, give year or date of discharge) 1953-1969 | | | 16b. SOCIAL SECURITY NO
309 34 3043 | | | 17. INFORMANT Address
Navy Records | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Carcinomatosis (Primary site not yet determined)
1541
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of rectum with metastases
DUE TO, OR AS A CONSEQUENCE OF
(c)
Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Unknown | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | |
| 21a. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21c. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 7 , 19 69 , to March 25 , 19 69 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 25 , 19 69 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE D W Shea M.D. | | | | | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
25 March 1969 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) D. W. SHEA, M. D. | | | | | | | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
3-29-69 | | | 23c. NAME OF CEMETERY OR CREMATORY
St. Joseph's Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Evansville Ind. | | | | | | | | | | |
| 24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS
1400 Chapin Street, N.W., Washington, D. C. | | | | | | | | | | 25a. REC'D BY REGISTRAR
MAR 28 1969 | | | 25b. REGISTRAR'S SIGNATURE
<i>W. W. Chambers</i> | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
04089
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH
04081
1
DECEASED-NAME
(Type or print)
First
ARDATH
Middle
6
Last
FRANTZ
2a. DATE OF DEATH
3 Month 23 Day Year 69
2b HOUR
6 28 P
3 SEX
F
4 RACE
W
5. DATE OF BIRTH
SEPT 10 18 89
6 AGE (n years
last birthday)
79 YRS
7 UNDER 1 YEAR
MONTHS
DAYS
IF UNDER 24 HRS.
HOURS
MIN
7a BIRTHPLACE (State or foreign
country)
Maryland
7b. CITIZEN OF WHAT COUNTRY?
USA
8 MARRIED
WIDOWED
NEVER MARRIED
DIVORCED
9. COUNTY OF DEATH
MONTGOMERY
10. CITY OR TOWN OF DEATH
SILVER SPRING
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
SYLVAN MANOR HOME
12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Homemaker
12b KIND OF BUSINESS OR
INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission)
STATE
6-6
13b COUNTY
13c CITY OR TOWN
Silver Spring
13d INSIDE CITY LIMITS?
YES
NO
13e STREET AND NUMBER
2375
14. FATHER'S NAME
First
6-7
Middle
Last
15 MOTHER'S MAIDEN NAME
First
Frances
Middle
Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, No, or Unknown
No
16b SOCIAL SECURITY NO
17 INFORMANT
FRANK FRANTZ
1512-LIVE
SILVER
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT
4361
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last
(b) ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
NONE
19a DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY?
YES
NO
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)
21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED
While Not while
at work at work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY
OFFICE BUILDING, ETC)
21f LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 8/5, 1963, to 3/23, 1969, that (I) (we) last
saw the deceased alive on 2-26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death
22b SIGNATURE
Henry Stout me MD
22c DATE SIGNED
3/23/69
22d. PHYSICIAN'S
NAME (Type)
HENRY W. STOUT
22e ADDRESS
10011 GEORGIA AVE SILVER SPRING MD
23a BURIAL CREMATION
REMOVAL (Specify)
23b DATE
23c NAME OF CEMETERY OR CREMATORY
23d LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR
25a REC'D BY REGISTRAR
DATE
25b REGISTRAR'S SIGNATURE

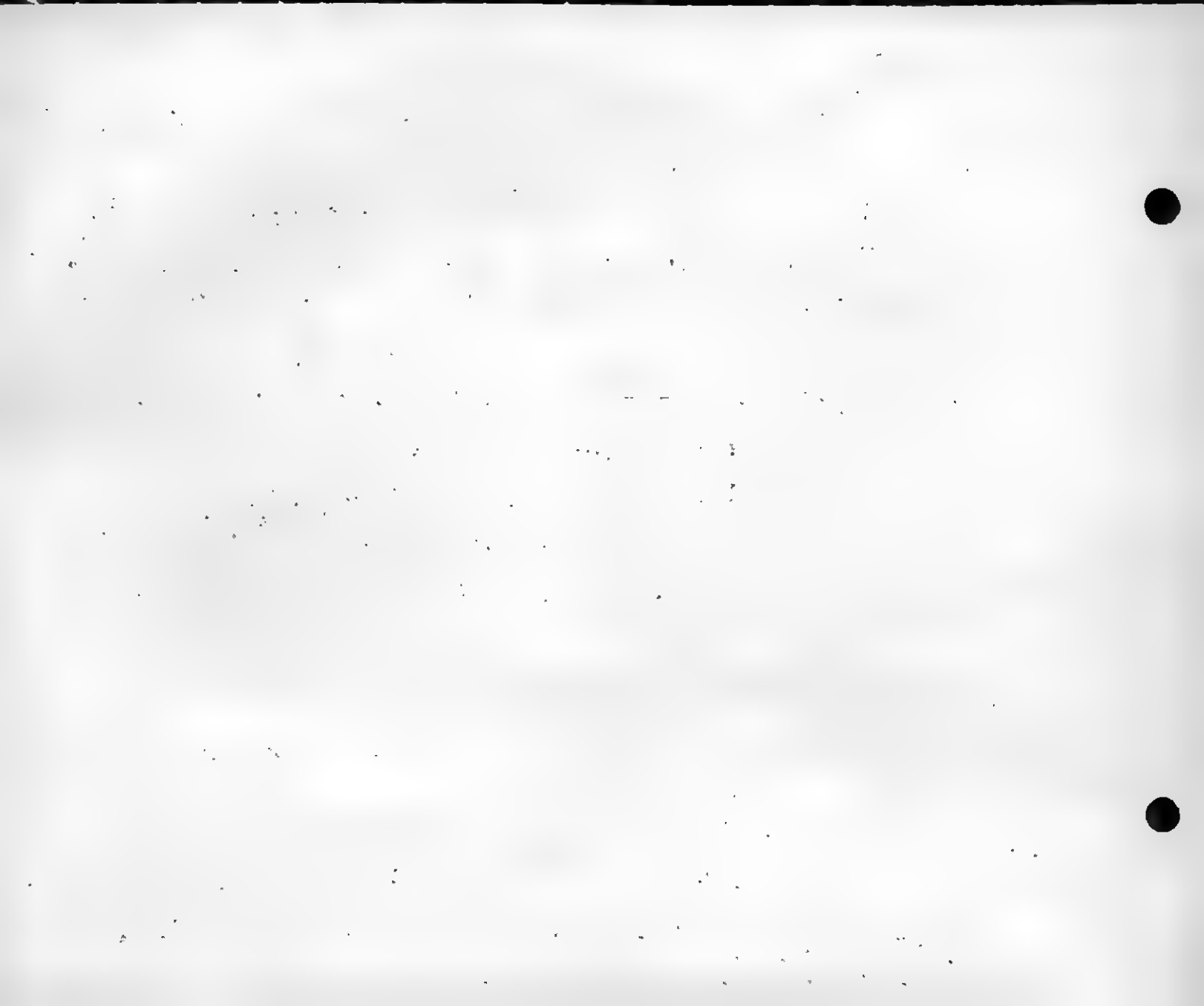
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04090

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) George W. FReas | | | 2a. DATE OF DEATH
Month 3 Day 26 Year 1969 | | | 2b. HOUR
6:30 PM | |
| 3 SEX
male | | 4. RACE
white | | 5 DATE OF BIRTH
5-6-96 | | 6 AGE (in years last birthday)
72 YRS | |
| 7a BIRTHPLACE (State or foreign country)
md. | | 7b. CITIZEN OF WHAT COUNTRY?
u.s.a. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Montgomery Co. | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hosp. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Act. Adm. Asst. of Defense | | 12b KIND OF BUSINESS OR INDUSTRY
Dept. | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
D.C. | | 13b COUNTY
Washington D.C. | | 13c CITY OR TOWN
Washington D.C. | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e STREET AND NUMBER
321 ASPEN ST. N.W. | | | | | | | |
| 14 FATHER'S NAME
First Levi Middle Freas | | | 15. MOTHER'S MAIDEN NAME
First Elizabeth Middle Menze | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) YES | | 16b SOCIAL SECURITY NO
579-09-1405A | | 17 INFORMANT
Mrs. Helen O. Freas Address 321 Aspen St., N.W., D.C. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myelofibrosis - Atypical Lymphoma
DUE TO, OR AS A CONSEQUENCE OF (b) Gram negative sepsis (clinical)
DUE TO, OR AS A CONSEQUENCE OF (c) Myeloproliferative disorder manifest as | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
(R) A-K amputation for cellulitis + necrosis | | | | | | | |
| 19a DATE OF OPERATION
1 March 69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 15 Jan 1969 , to 20 March 1969 , that (I) (we) lost saw the deceased alive on 26 March 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
Eugene P. Libre | | DEGREE
MD | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED
27 March 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
Eugene P. Libre | | 22e. ADDRESS
10400 Connecticut Ave., Kensington, Md. | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
March 29, 1969 | | 23c NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04091 CERTIFICATE OF DEATH 04083 | | | | | | | | | |
| 1 DECEASED NAME (Type or print) First Middle Last
FRANK Celia L. FREUND | | | | | 2a. DATE OF DEATH Month Day Year
3 8 69 | | | | |
| 3 SEX
F | | 4 RACE
W | | 5 DATE OF BIRTH
June 20, 1885 | | 6 AGE (In years last birthday)
83 YRS. | | 7b. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Murray, Minnesota | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
CHRYCHASE NURSING HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND 13b. COUNTY
2603 Glenallen Ave. | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2603 Glenallen Ave., | | | |
| 14 FATHER'S NAME First Middle Last
James James Smith | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Eleanor hocoore | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
none | | 17 INFORMANT Address
Eleanor McBreen, 13 a, b, c, d, e above | | | | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease and</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>rheumatoid arthritis</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 d.
3 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Rheumatoid arthritis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1419</u> , 19 <u>65</u> , to <u>March 8, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 7, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Dorothy Gill, M.D.</u> | | | | | 22c. DATE SIGNED
March 7, 1969 | | 22d. PHYSICIAN'S NAME (Type)
Dorothy Gill | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
11 Mar. 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
CALVARY CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
Springfield, Illinois | | | |
| 24 FUNERAL DIRECTOR
Rinaldi Funeral Home Washington, DC 20012 | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 11 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 04092 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04084 | |
|--|--|--|--|---|--------------------------|--|--|
| 1 DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | |
| First Middle Last
CARON (No MIDDLE) FULTON | | | | | Month Day Year
3 3 69 | | |
| 3. SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH
3/12/1867 | | 6 AGE (in years last birthday)
101 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
OHIO | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
NSG & CONVALESCENT CENT | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
FARMER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USCA. RESIDENCE (Where deceased lived, if institut. of residence before admission) STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
BETHESDA | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
HENRY FULTON | | 15. MOTHER'S MAIDEN NAME First Middle Last
LETTICE PANCOSTE | | 13e. STREET AND NUMBER
5303 Pooks Hill Road | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
NO | | 16b. SOCIAL SECURITY NO.
284-24-3971 | | 17. INFORMANT Address
ANN BRONSON 5303 POKS HILL RD BETHESDA | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Pancreas</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Pancreas</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 1965, to March 3, 1969, that (I) (we) last saw the deceased alive on March 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
John D. Herman M.D. | | | | 22c. DATE SIGNED
MARCH 3, 1969 | | 22d. ADDRESS
4801 Montgomery La. Bethesda, Md. | |
| 23a. BURIAL CREMATION REMOVAL (Specify)
Burial | | 23b. DATE
3-7-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Montg. Co. Md. | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Md. | | | | 25a. REC'D BY REGISTRAR
MAR 12 1969 | | 25b. REGISTRAR'S SIGNATURE | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1

04093

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04085

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1 DECEASED-NAME
(Type or print) First Middle Last
HARVEY NONE GAMBRILL | | | 2a. DATE OF DEATH
3 Month 13 Day 69 Year | | | 2b. HOUR
9:25 P.M. | |
| 3 SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
11-28-86 | | 6. AGE (in years last birthday)
82 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
TEXAS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
WASH. SAN. & HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
STEAM FITTER | | 12b. KIND OF BUSINESS OR INDUSTRY
RETIRED | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE
Md. | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
TAKOMA PARK | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | 13e. STREET AND NUMBER
7125 Willow Av. | | | |
| 14 FATHER'S NAME First Middle Last
SAMUEL GAMBRILL | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Lillian Ridgeway | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO
579-03-814 | | 17 INFORMANT
Hospital Records | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 weeks |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Arteriosclerotic Cardiovascular disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1967 , 19____, to March 13, 1969 , that (I) (we) last saw the deceased alive on March 13, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
James M. Whitlock | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
3-13-69 | |
| 22d. PHYSICIAN'S NAME (Type)
JAMES M. WHITLOCK | | | | 22e. ADDRESS
7717 Caroline Takoma Park Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Buried | | 23b. DATE
March 17, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
East Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Md | |
| 24. FUNERAL DIRECTOR
Funeral Home, Inc 254 Carroll St. Xb | | | | REC'D BY REGISTRAR
Mar 18 1969 | | 25b. REGISTRAR'S SIGNATURE
William J. Judge | |

VR 115 45M



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cleared by Dr. [Signature]

| 04094 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04086 | | |
|--|--|---|---|---|--|---|--|--|---|--|--|--|
| Item #5, Film 111 4/7 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) First Middle Last
Orem Aquilla Gardner | | | | | | 2a DATE KNOWN OF DEATH
Month 3 Day 24 Year 1969
ESTIMATED <input checked="" type="checkbox"/> 3XX24X167X6XX8X16X | | | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
6/15/26 94 | | 6 AGE (in years last birthday)
74 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country)
Maryland | | | 7b CITIZEN OF WHAT COUNTRY?
USA | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hosp | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Postmaster | | | 12b KIND OF BUSINESS OR INDUSTRY
Post Office | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | | 13b COUNTY
Queen Anne | | 13c CITY OR TOWN
Chester | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | | |
| 14. FATHER'S NAME First Middle Last
William E Gardner | | | | | | 15 MOTHER'S M A D E N NAME First Middle Last
Virginia Harris | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes WW I | | | | 16b SOCIAL SECURITY NO
213-22-6476 | | 17 INFORMANT
Mrs Virginia Robinson 16215 Woodman Circle S.W. of Md | | | | ADDRESS | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Artery Heart Disease
(b) Coronary Artery Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day Year
HOUR A.M. P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No | | City or Town | | County State | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL EXAMINER'S NAME (Type)
BELDEN R. REAP M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b DATE SIGNED
3/24/1969 | | | | | | |
| 23a BURIAL, CREMATION, OR REMOVAL (Specify)
Burial | | 23b DATE
3-25-69 | | 23c NAME OF CEMETERY OR CREMATORY
Stevensville Cemetery | | | | 23d LOCATION (City or Town) (County) (State)
Stevensville Maryland | | | | |
| 24 FUNERAL DIRECTOR
500 University Blvd. W. Silver Spring Md | | | | | | 25a REC'D BY REGISTRAR
DATE APR 1 1969 | | 25b REGISTRAR'S SIGNATURE
[Signature] | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04095

CERTIFICATE OF DEATH

04087

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print)
Annie V. Garrett | | | 2a. DATE OF DEATH
Month Day Year
March 3 1969 | | | 2b. HOUR
6:40 PM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Sept. 26, 1875 | | 6. AGE (In years
lost birthday)
93 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Park Haven Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY
At Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3611 Littledale Road | |
| 14. FATHER'S NAME First Middle Last
Samuel P. Trewolla | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Virginia Carter | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
Arthur L. Garrett | | Address
Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>
412° DUE TO, OR AS A CONSEQUENCE OF
Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 Days 1 1/2 years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 10, 1966, to March 3, 1969, that (I) (we) lost saw the deceased alive on March 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Neil P. Campbell | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/3/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Neil P. Campbell | | | | 22e. ADDRESS
1629 Columbia Rd | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
3/6/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland Maryland | | | |
| 24. FUNERAL DIRECTOR
J. Wm. Lees Sons, Co. | | | | ADDRESS
300 4th St., NE Washington, DC | | 25a. REC'D BY REGISTRAR
DATE MAR 7 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

FOR-STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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71

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04088 | | |
|--|--|--------------------|---|---|--------|---|------|--|--|--|----------------------------------|--|
| 04096 | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | |
| 1 DECEASED NAME
(Type or Print) | | | First | | Middle | | Last | | 2a DATE KNOWN OF ESTI-
DEATH MATED <input type="checkbox"/> Month Day Year 2b HOUR | | | |
| MACION | | | E | | BARVEY | | | | | 3 14 1969 10:35 PM | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (in years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | 2c DATE PRONOUNCED DEAD Month Day Year 2d HOUR | | |
| 7 | | W | | 4/5/1905 | | 6.3 YRS | | | | 3 14 1969 11:08 PM | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | | |
| Pennsylvania | | | USA | | | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | | Suburban Hospital | | | | | | Home maker | | Home | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| Pennsylvania | | | WELLSBURG | | | Oil City | | | | | 410 Plummer St. | |
| 14 FATHER'S NAME First Middle Last | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| Frank Barrett | | | Julia Connor | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT ADDRESS | | | | | | |
| No | | | unknown | | | Cornelius Barvey - Husband. addressee | | | | | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 711X | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) obstruction of larynx | | | | | | | | | | 5 min. | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration of meat bolus | | | | | | | | | | 1/2 hr. | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year HOUR AM | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | |
| | | | | 10 PM 3 14 1969 | | | | Choked on large piece of meat. | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory office building, etc.) | | | | 21f. LOCATION Street or RFD No City or Town County State | | | | |
| | | | | Restaurant | | | | 3300 W. Potomac Ave. Washington - D.C. | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | John G. Ball | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | John G. Ball, M.D. | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | March 15, 1969 | | |
| | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| | | | | | | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Removal | | 3/15/69 | | Calvary Cemetery | | | | Oil City, Pennsylvania | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REG. STRAR DATE | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Joseph Gawler's Sons, Inc., Wash., D. C. | | | | MAR 20 1969 | | | | James Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 144
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04097

04089

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. DECEASED NAME
(Type or print) Marie H. Geraci | | First Marie Middle G. Last Geraci | | 2a. DATE OF DEATH
3 Month 29 Day 69 Year | | 2b. HOUR
7:45 | |
| 3 SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
10-12-87 | | 6. AGE (in years last birthday)
81 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
WASH. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Suburban | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)
At home | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
4616 Chase Avenue | | 14. FATHER'S NAME First VENANZIO Middle Giovannetti Last | | 15. MOTHER'S MAIDEN NAME First Angelina Middle Cuneo Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO
— | | 17. INFORMANT
Veronica Bilicki | | Address Fairfax Rd. Bethesda, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIO-SCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 HRS
CRAPPA
6 YRS |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from CCT. , 19 68 , to 3/29 , 19 69 , that (I) (we) last saw the deceased alive on 3/29 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/29/69 | |
| 22d. PHYSICIAN'S NAME (Type)
DR. LEO DOWDYAN
2215 WISCONSIN AVE | | | | 22e. ADDRESS
BETHESDA MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
4-1-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Md. | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016 | | | | 25a. REC'D BY REGISTRAR
APR 7 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-141
45M - 11-69

| 04098 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04090 | | |
|---|--------|---|---|--|--------|---|------------------------------------|--|
| 1 DECEASED NAME
(Type or print) | | | | First | Middle | Last | 2a DATE OF DEATH
Month Day Year | 2b HOUR
M |
| FRANCESCA J. Gilbert | | | | | | | March 10 1969 | 12:00 |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 UNDER 1 YEAR
MONTHS DAYS | | 8 UNDER 24 HRS
HOURS MIN |
| FEMALE | White | 3-19-02 | | 66 | | 11 21 | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | |
| | | USA | | | | Montgomery | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY |
| Bethesda | | | Suburban | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INS DE CITY, TOWNSHIP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER |
| MD | | Montgomery | | Chevy Chase | | YES | | 4611 DAVIDSON DR |
| 14 FATHER'S NAME First Middle Last | | | 15 MOTHER'S M A D E N NAME First Middle Last | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | |
| Joseph Charles J. Filipp | | | Luzina de Reggi | | | NO | | |
| 16b SOCIAL SECURITY NO. | | | 17 INFORMANT | | | Address | | |
| 214-32-9969 | | | Nathan R. Gilbert | | | Same as Item 13. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Alcoholism</u>
<u>1830</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Coronary Artery Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Pleural effusion & Treatment effusion</u> | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | |
| | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | |
| 22b SIGNATURE <u>Eugene P. Librie MD</u> | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED <u>10 March 69</u> |
| 22d PHYSICIAN'S NAME (Type) <u>EUGENE P LIBRIE</u> | | | | 22e ADDRESS <u>10400 Conn. Ave. Kensington, Md.</u> | | | | |
| 23a BURN, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | |
| CREMATION | | 3-13-69 | | CEDAR HILL | | SUITLAND MARYLAND | | |
| 24 FUNERAL DIRECTOR <u>ROBERTA A. KEMPNEY</u> | | | | ADDRESS <u>7557-4150 DIVISION AVE BALTIMORE, MD</u> | | 25a REC'D BY REG STRAR <u>MAR 14 1969</u> | | 25b REG STRAR'S SIGNATURE <u>[Signature]</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04099

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04091

| | | | | | | | | | | |
|---|--|---|---|---|--|---|---|---|---------------------|------------------------------|
| 1. DECEASED-NAME
(Type or print) | | | First
Robert | Middle
Allan | Lost
GILBERTZ | 2a. DATE OF DEATH
March Month 16 Day 1969 | | | 2b. HOUR
1215A M | |
| 3 SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
Nov. 1, 1925 | | 6. AGE (in years
last birthday)
43 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Naval Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
U. S. Marine Corps | | 12b. KIND OF BUSINESS OR
INDUSTRY
N/A | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 3a. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3934 Bel Pre Road | | |
| 14. FATHER'S NAME
First Middle Last
Unknown-deceased CLARENCE E. GILBERTZ | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Unknown-deceased BARBARA SPRINGER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
Yes | | 16b. SOCIAL SECURITY NO
1944-69 | | 17. INFORMANT
Address
Marine Corps/hospital records | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Adenocarcinoma, parotid region with widespread metastases</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Feb. 15</u> , 19 <u>69</u> , to <u>Mar. 16</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>Mar. 16</u> , 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>G. W. Taylor</u> M.D. | | | | | 22c. DATE SIGNED
Mar. 17, 1969 | | 22d. PHYSICIAN'S NAME (Type)
G. W. TAYLOR, M. D. | | | |
| 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-19-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City or Town)
Arlington | | (County)
Arlington | | (State)
Va. |
| 24. FUNERAL DIRECTOR Joseph Gawler Sons ADDRESS
5130 Wisconsin Ave., N.W., Washington, D. C. | | | | | 25a. REC'D BY REGISTRAR
DATE APR 20 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>James J. Jones</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refile on page 1. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|---|---|---|----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First Middle Last | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Donald | | | W. GLADNEY | | March Month 3 Day Year 69 | | | 1230 P.M. | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years lost birthday) | | 7 IF UNDER 1 YEAR | | |
| Male | | Caucasian | | Aug. 28, 1906 | | 62 YRS | | MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | |
| Texas | | USA | | | | Montgomery Md | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | Naval Hospital | | | U. S. Navy | | N/A | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | |
| Virginia | | | Fairfax | | Fairfax | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4124 Orchard Drive | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Donald W. Gladney, Sr. | | | Catherine Smith | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | | |
| yes | | | 1930-59 | | Mrs. Ruth Gladney, 4124 Orchard Dr. Fairfax Virginia | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple pulmonary abscesses | | | | | | | | | | |
| 150X DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma of esophagus | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Feb. 11, 1969, to Mar. 3, 1969, that (X) (we) last saw the deceased alive on Mar. 3, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | 22c DATE SIGNED | | |
| F. H. O'CONNEL, M.D. | | | | | | | | Mar. 4, 1969 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | |
| F. H. O'CONNEL, M.D. | | | | Naval Hospital, Bethesda, Maryland | | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Spec W) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Cremation | | 3-5-69 | | Cedar Hill Crematory | | Suitland Md. | | | | |
| 24 FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Everly Funeral Home | | | | DATE MAR 7 1969 | | Charles Judge | | | | |
| Fairfax, Virginia C. M. West | | | | | | | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 23b, 23c, 23d
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Fun. Dir. jcp 04101 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04093

| | | | | | | | | | |
|--|------------------------|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) LESTER | | Middle | | Last | | 2a. DATE KNOWN
OF DEATH 3 16 19 69 | | 2b. HOUR
3:30 | |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH
11-9-22 | 6 AGE (In years
last birthday)
46 YRS | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year
3 16 19 69 | |
| 7a. BIRTHPLACE (State or foreign
country) PA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | Md | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
SALESMAN | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before
admission) STATE MD. | | 13b. COUNTY Montg. | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
11430 Ambler Ave | |
| 14. FATHER'S NAME First Middle Last | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes no, or unknown) YES | | (If yes give war or dates of service)
WW II | | 16b. SOCIAL SECURITY NO
140-12-5581 | | 17. INFORMANT
DR. IBA CHIDEL | | ADDRESS
11405 COLUMBIA PIKE
SILVER SPRING MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Eysanguination due
756X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) to Laceration of Throat,
DUE TO, OR AS A CONSEQUENCE OF
(c) self-inflicted | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Severe Depression | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
24 3-16-69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18)
deceased depressed, cut his
throat with knife | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
home | |
| 21f. LOCATION Street or R.F.D. No
11430 Ambler Ave, S.S. Montg, Md. | | City or Town | | County | | State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL
SIGNATURE Belden R. Reap | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASS STANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
3/16/1969 | |
| EXAMINER'S
NAME (Type) BELDEN R. REAP M.D. | | ADDRESS 232 Carroll | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS 232 Carroll | | | |
| 23a. BURIAL CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE 3-18-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Hebrew Memorial | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR Donald M. Stein | | ADDRESS 232 Carroll | | 25a. REC'D BY REGISTRAR
MAR 19 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 411 Maryland State Department of Health
4-7-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04094

04102

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|-------------------------|--|------------------------------|---|------------------------------|--|--|
| 1 DECEASED NAME
(Type or Print) IRINA | | First Middle Last GOLOVKO | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 3-24 1969 | | 2b. HOUR 4:45 AM | |
| 3 SEX
FEMALE | 4. RACE
WHITE | 5 DATE OF BIRTH
5/5/84 | 6 AGE
years 84 YRS | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN | 2c. DATE PRONOUNCED DEAD
Month 3 Day 24 Year 1969 | |
| 7a BIRTHPLACE (State or foreign country)
RUSSIA | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY | |
| 10 CITY OR TOWN OF DEATH
SILVER SPRING | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
Sil. Spr. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First Middle Last
Efim Shuranleff | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Domna Poliakoff | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
Katherine Golovko 11428 Maple View Dr. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | EXAMINER'S NAME (Type)
Belden R. Reap, M.D., Wheaton | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
March 24, 1969 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/27/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | |
| 24. FUNERAL DIRECTOR
ADDRESS
The S. H. Hines Company Washington, | | | | 25a. REC'D BY REGISTRAR
MAR 26 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>William A. Underhill</i> | |

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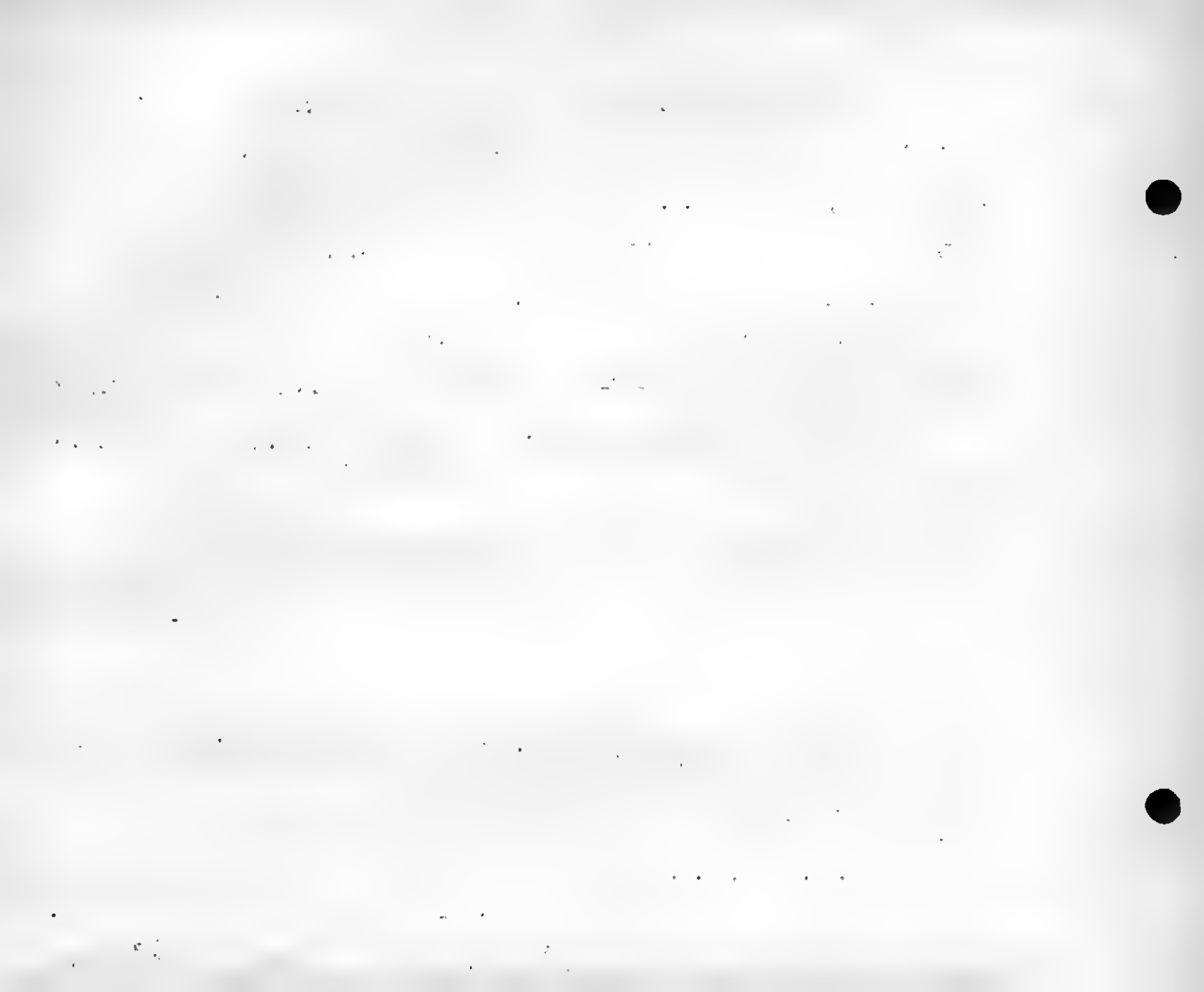
18

19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|---|--|---|--|--------------------------------|--|
| 04103 | | CERTIFICATE OF DEATH | | | | | | 04095 | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR |
| WALTER ROBERT GOVER | | | | | | MARCH 28 1969 | | | 800P M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| MALE | | CAUCASIAN | | 5 JUN 1917 | | 51 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| ENOSBURG FALLS, VT | | U.S. | | | | MONTGOMERY COUNTY Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BETHESDA | | NAVAL HOSPITAL | | U.S. NAVY | | | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| VIRGINIA | | | | | ALEXANDRIA | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1718 OAKCREST DR |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| WALTER A GOVER | | | MARY HAMEL | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| Yes <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 0080-58-638 | | KATHRYN GOVER 1718 OAKCREST DR ALEX., VA | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE ESOPHAGUS WITH WIDESPREAD METASTASIS</u> | | | | | | | | | 6 months |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 21 MARCH 1969, to 28 MARCH 1969, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 28 MARCH 1969, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>W. R. Hix</i> | | | | | DEGREE
ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type)
W. R. HIX, M.D. | | | | | 22e. ADDRESS
NAVAL HOSPITAL, BETHESDA, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 4-2-69 | | ARLINGTON NAT'L | | ARLINGTON | | VA. | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| EVERLY-WHEATLEY FUNERAL HOME | | 1500 W. BRADDOCK RD | | APR 7 1969 | | Charles Judge | | | |



04096

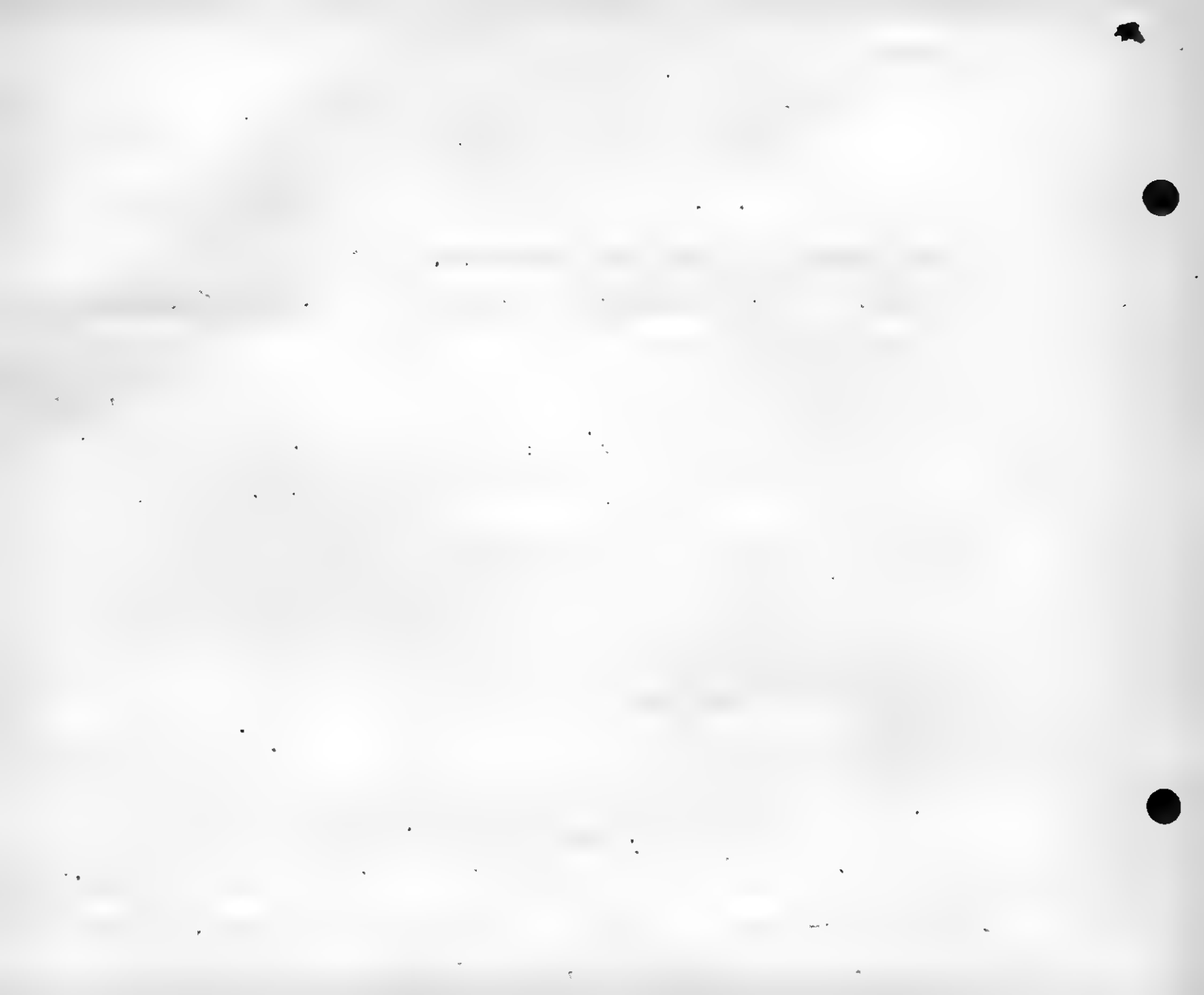
04104

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(Type or print) Marie G. Gready | | | 2a. DATE OF DEATH
Month 3 Day 6 Year 69 | | | 2b. HOUR
10:08 M | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
2/18/1908 | | 6. AGE (In years last birthday)
71 YRS | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Stoke Newington Md | |
| 10. CITY OR TOWN OF DEATH
Silvers Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
KENSINGTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First Edward F. Middle Gallagher Last Gallagher | | 15. MOTHER'S MAIDEN NAME
First Mame Middle Full Last Full | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO.
220-44-53541 | | 17. INFORMANT
Neice | | 18. ADDRESS
1544 ss Hardwood Lane McLean, Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1/69 to 3/6/69 , that (I) (we) last saw the deceased alive on 3/6/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | |
| 22b. SIGNATURE
John J. Curry | | 22c. DATE SIGNED
3/6/69 | | 22d. PHYSICIAN'S NAME (Type)
JOHN J. CURRY | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-10-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown, Maryland | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY-REGISTRAR
1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| 04105 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04097 | |
| Items 586 Film 411 4/11/69 kk | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Edith</i> | | | First <i>H.</i> Middle <i>Green.</i> Last | | | 2a. DATE OF DEATH
Month <i>March</i> Day <i>5</i> Year <i>1969</i> | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Caucasian</i> | | 5. DATE OF BIRTH <i>7/27/1884</i> | | 6. AGE (In years last birthday) <i>84</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Minn.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md | |
| 10. CITY OR TOWN OF DEATH <i>Wheaton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kendall Hills Nursing Home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Kensington</i> | | 13d. INSIDE CITY (Lot 157) YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First <i>Unknown</i> Middle Last | | 15. MOTHER'S MAIDEN NAME First <i>Hildegard</i> Middle Last <i>UNKNOWN</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>No</i> | | | |
| 16b. SOCIAL SECURITY NO <i>214 01 2575 D</i> | | 17. INFORMANT <i>W. Wash. I Green</i> | | Address <i>3605 Chevy Chase Lake Chevy Chase Md</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Infarction</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Thrombosis</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral Arteriosclerosis</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/1/65</i> , to <i>3/5/69</i> , that (I) (we) last saw the deceased alive on <i>3/4/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | |
| 22b. SIGNATURE <i>Robert A. Humphrey</i> | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>3/5/69</i> | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, <i>Burial</i> | | 23b. DATE <i>March 8, 69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rockville cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Rockville Mont. Md</i> | |
| 24. FUNERAL DIRECTOR <i>Robert A. Humphrey 7557-Weiss Ave</i> | | | | 25a. REC'D BY REGISTRAR <i>MAR 12 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>James E. Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

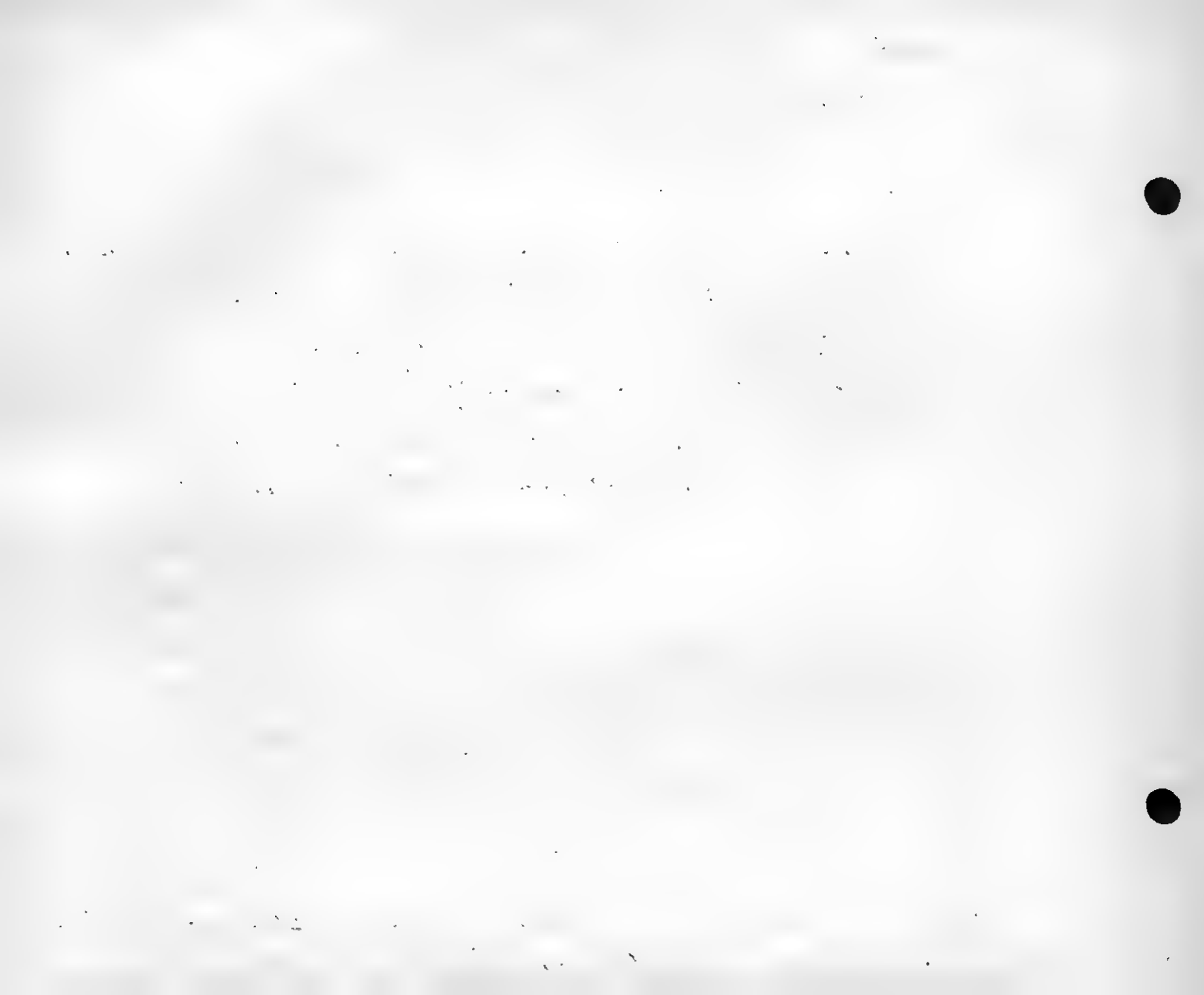
04106

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04098

CERTIFICATE OF DEATH

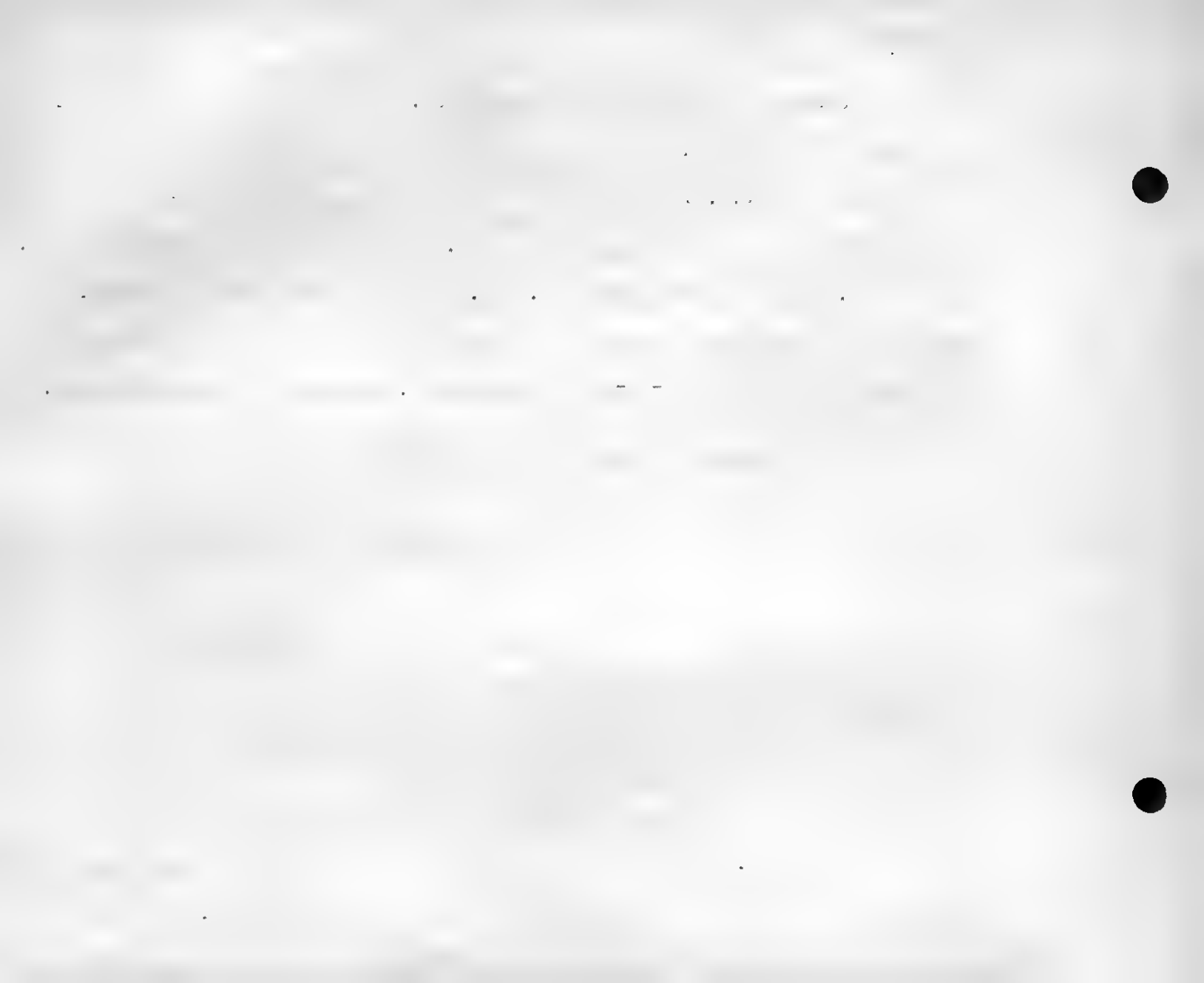
| | | | | | | | | | |
|---|------------------------|---|------------------------------------|--|--|---|--|---|------|
| 1 DECEASED NAME
(Type or print) HARRY | | First | Middle | Last | 2a. DATE OF DEATH
Mar Month 23 Day Year 69 | | 2b. HOUR
6:45 PM | | |
| 3 SEX
Male | 4 RACE
White | | 5. DATE OF BIRTH
2-14-99 | | 6 AGE (In years
last birthday)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
MD | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
CAB DRIVER | | 12b KIND OF BUSINESS OR INDUSTRY
TAXI | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE
MD | | 13b COUNTY
P. G. | | 13c CITY OR TOWN
HIAWATHA | | 13d INS. OF CITY LIMITS?
YES | | 13e STREET AND NUMBER
1005 CHILLUM ROAD | |
| 14. FATHER'S NAME
UNKNOWN | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME
UNKNOWN | | First | Middle | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) YES | | 16b SOCIAL SECURITY NO
578-24-3424 | | 17. INFORMANT
Records | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) SEVERE CORONARY ARTERIOSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC. | | 21f. LOCATION
Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 196 19 69 , to 3/23 19 69 , that (I) (we) last saw the deceased alive on Mar 23 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert Kramer | | 22c. DATE SIGNED
Mar 23, 1969 | | 22d. PHYSICIAN'S NAME (Type)
ROBERTO KRAMER | | | | | |
| 22e. ADDRESS
8484-16th St. N. D.C. | | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | |
| 23a. BURIAL, CREMATION
or other disposal (Specify)
BURIAL | | 23b. DATE
3/25/69 | | 23c. NAME OF CEMETERY OR CREMATORY
NATH. MEM. PARK | | 23d. LOCATION (City or Town)
FALLS CHURCH VA. | | (County) (State) | |
| 24. FUNERAL DIRECTOR
Bea Beebe | | ADDRESS
4217 9th St | | 25a. REC'D BY REGISTRAR
Mar 26 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 04107 CERTIFICATE OF DEATH 04099 | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Joseph William Gregory, Jr. | | | | | | Month 3 Day 20 Year 69 | | 2:55 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | |
| Male | | White | | 10-28-04 | | 64 YRS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | | U.S.A. | | | | Montgomery County Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | | | Holy Cross Hosp. | | | Manager | | Paint & Hard. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | Montgomery | | Sil. Spr. | | YES | | 9802 Forest Grove Rd. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Joseph William Gregory | | | Carrie Mae Springmann | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| No | | | 214-03-8086 | | Elizabeth D. Gregory 9802 Forest Grove Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thrombosis & Myocardial Infarction</u> | | | | | | | | | 2 hours | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1963, to _____, 1969, that (I) (we) last saw the deceased alive on _____, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE-SIGNED | | | | |
| William D. And, M.D. | | | | | | 3/20/69 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | |
| William D. And, M.D. | | | | | | 9006 Colesville Road, Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 3/24/69 | | Fort Lincoln Cemetery | | Bladensburg, Maryland | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Glen Carter 8434 Georgia Avenue | | | | MAR 28 1969 | | | | | | |
| Warner E. Pumphrey, Inc. Silver Spring, Maryland | | | | | | | | | | |



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | 04:00 | |
|---|--|---|--|--|---|--|--|--|---------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 04108 Item 23 Film 411 4/2/69 kk | | | | | | | | | | CERTIFICATE OF DEATH | |
| 1 DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a DATE OF DEATH
Month Day Year | | | 2b HOUR | | |
| BABY | | | BOY | | | GROOMS | | | 3 23 69 | | |
| 3 SEX
MALE | | 4 RACE
NEGRO | | 5 DATE OF BIRTH
3-23-69 | | 6 AGE (in years last birthday)
YRS | | 7 UNDER 1 YEAR
MONTHS DAYS | | 8 UNDER 24 HRS.
HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | | | | | |
| 10 CITY OR TOWN OF DEATH
OLNEY | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MONTGOMERY GENERAL HOSP. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
NEWBORN | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b COUNTY
MONTGOMERY | | 13c CITY OR TOWN
GAITHERSBG. | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER
17930 LAYTONSVILLE ROAD | | | |
| 14 FATHER'S NAME
First Middle Last
JAMES LELAND WILCOX | | | 15 MOTHER'S MAIDEN NAME
First Middle Last
DENISE DARCEL GROOMS | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
NO | | | 16b SOCIAL SECURITY NO. | | 17. INFORMANT
Address
MEDICAL RECORDS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PREMATURITY</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>3-23</u> , 19 <u>69</u> , to <u>3-23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3-23-69</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Chester Lee Roy Wagstaff</i> | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-24-69 | | | |
| 22b. PHYSICIAN'S NAME (Type)
CHESTER LEEROY WAGSTAFF, M.D. | | | | 22e. ADDRESS
MEDICAL CENTER, SANDY SPRING, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE
3/23/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Hunter Laboratory | | 23d. LOCATION (City or town) (County) (State) | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS | | | | | | 25a. REC'D BY REGISTRAR
DATE
MAR 26 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

AT 5
304 REV 1-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
|--|--|--|--|--|----------------------|---|------|--|---|--|--|--|---------------------|------------------------------|--|
| 04109 | | | | | CERTIFICATE OF DEATH | | | | | 04101 | | | | | |
| 1. DECEASED-NAME
(Type or print) <u>ROTH</u> | | | First | | Middle | | Last | | | 2a. DATE OF DEATH
3 Month 5 Day 69 Year | | | 2b. HOUR
7:15 AM | | |
| 3. SEX
FEMALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
11-29-99 | | | 6. AGE (in years last birthday)
69 YRS | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
U.A. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery County Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring Md | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Md. | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Wheaton | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
4011 Randolph Road | | | |
| 14. FATHER'S NAME
First Middle Last
Preston | | | 15. MOTHER'S NAME
First Middle Last
Josephine Potts | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | 16b. SOCIAL SECURITY NO.
220-44-4643 | | | 17. INFORMANT
Hospital Record - Silver Spring, Md | | | Address | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Klebsiella pneumoniae</u>
<u>2507</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Secretory Ovarian Cystic Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Dysphagia</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>8 weeks</u> | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>1) Diabetes Mellitus - Generalized Arteriosclerosis - Old CVA's - Left Hemiparesis</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, not by medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>68</u> , to <u>March 5</u> , 19 <u>69</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>Feb 4</u> , 19 <u>69</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Michael Dobridge</u> | | | DEGREE
ATTENDING PHYS. | | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | | | 22c. DATE SIGNED
<u>March 5, 1969</u> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Michael Dobridge | | | 22e. ADDRESS
9811 Georgia ave N W | | | Silver Springs Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
March 8, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Pro Geo Md. | | | | | | |
| 24. FUNERAL DIRECTOR
F. Gasch's Sons Hyattsville, Md. | | | ADDRESS | | | 25a. RECD BY REGISTRAR
MAR 10 1969 | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | |

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 1 & 22a Film 412 Maryland State Department of Health
5-22-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04110

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04102

| | | | | | | | | | |
|--|--------|---|-----------------------------------|---|---------------|---|--|---|---|
| 1. DECEASED-NAME
(Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | | 2b. HOUR |
| JAMES | | | A | | HAMILTON | 3-18 1969 | | | 6:35 PM |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years
last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | |
| MALE | WHITE | 8/1/02 | 66 YRS | | | | | 3 Day 18 Year 1969 | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| MARYLAND | | U.S.A. | | | | MONTGOMERY | | | |
| 1d. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| SILVER SPRING | | HOLY CROSS HOSP. | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Mont. | | Sil. Spr. | | | | 420 University Blvd. W. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| Oliver W. Hamilton | | | | | | Edith Sandy | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | | | ADDRESS |
| No | | | 579-05-9044 | | Doris Gray | | | | Item # 13 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral infarction with thrombosis | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| Cerebral arteriosclerosis | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arteriosclerotic heart disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day Year
HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | 19 | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | State |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 3/19/1969 | | | |
| BELDEN R. REAP, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 23a. BURIAL, CREMATION
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) |
| Burial | | 3/22/69 | | Parklawn Memorial Park | | Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Tyson Wheeler Funeral Home-1331 Rockville Pike | | | | Rockville, Md. | | MAR 26 1969 | | Charles J. Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-----------|--|------------------|--|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month Day Year | | |
| Raymond | | | Mahlon | | HAMILTON | | March | | 31 69 | | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH | | | 6 AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Male | | Caucasian | | March 6, 1903 | | | 66 | | 0 25 | | |
| 7a BIRTHPLACE (State or foreign
country) | | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| Arkansas | | | USA | | | | Montgomery | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR
INDUSTRY | | |
| Bethesda | | | Naval Hospital | | | Marine Corps (Ret) | | | Bandsman | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before
admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY, J.M.T.S? | | 13e STREET AND NUMBER | | |
| D. C. | | | | | Washington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2025 Eye St., N.W. | | |
| 14 FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S M.A.D.N. NAME First
Middle Last | | |
| Unknown | | | | | | | | | Unknown | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes, give war or dates of service) | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | | Address | | | |
| Yes | | | WWII - 4 577 42 3784 | | Washington | | | D.C. | | | |
| | | | | | Mrs. Mary Hamilton, 2025 Eye St., N.W. | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardiomyopathy with multiple old infarcts | | | | | | | | | | | |
| 4d5X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| Carcinoma of the lung with metastases | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | Yes | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | | | |
| 21a INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET FACTORY)
OFFICE BUILDING, ETC. | | | 21f LOCATION Street or R.F.D. No. | | | City or Town County State | | |
| | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Mar. 30, 1969, to Mar. 31, 1969, that (X) (we) last
saw the deceased alive on Mar. 31, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the
causes stated above, (X) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | DEGREE | | | 22c DATE SIGNED | | |
| T.M. Schenk | | | | | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | 2APRIL69 | | |
| 22d PHYSICIAN'S
NAME (Type) | | | | | | 22e ADDRESS | | | | | |
| T. M. SCHENK | | | | | | Naval Hospital, Bethesda, Md. | | | | | |
| 23a BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | | APRIL 4/69 | | Arlington National Cem. Arlington | | | Arlington Va. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a RECD BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | |
| Hysong Funeral Home | | | | | | Charles M. Hysong | | | Charles Judge | | |
| 1300 N Street, N.W. Washington, D. C. | | | | | | DATE APR 7 1969 | | | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|---|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04112 Items#23a,b,c,d Film 3411 4/3/69 | | | | | | | | | |
| 04104 | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Baby Boy Hansen | | | | | March 25 1969 | | | 9:40 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | |
| Male | | White | | 3/25/69 | | YRS | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Olney | | Montgomery General Hospital | | none | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Montgomery | | Silver Spring | | NO | | 2705 Briggs Road | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| | | | Kathleen Louise Hansen | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | | | | |
| no | | none | | records Address Montgomery General Hospital, Olney, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>immaturity</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>premature labor</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or RFD No | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Chester Leroy Wagstaff</u> | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 3-26-69 | | |
| 22d. PHYSICIAN'S NAME (Type) Chester L. R. Wagstaff, M.D. | | | | | 22e. ADDRESS Sandy Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 3-26-69 | | 23c. NAME OF CEMETERY OR CREMATORY Hunter Laboratory | | 23d. LOCATION (City or Town) (County) (State) 915 19th St. n.w. Wash. D.C. | | | |
| | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. RECD BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | MAR 27 1969 | | <u>John J. Jones</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|---|--|---|--------------------------------|-------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04113 | | | | | | | | | |
| 04105 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b HOUR |
| RENA | | | LUCILLE HARAB | | | Month 3 Day 22 Year 69 | | | 1:50 PM |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| FEMALE | | - WHITE | | 5-30-19 | | 49 YRS. | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| New York | | USA | | | | Montgomery | | Md. | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USJA, OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| BETHESDA | | GROSVENOR LANE NURSING & CONVALESCENT CENTER | | CLERK | | GOVERNMENT | | | |
| 13a USAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 3d INSIDE CITY, Y.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| MARYLAND | | Montgomery | | ROCKVILLE | | | | 13203 BLAXFIELD CT. | |
| 14 FATHER'S NAME First Middle Last | | | 15 MOTHER'S M A DEN NAME First Middle Last | | | | | | |
| JOSEPH I. POSNER | | | MIRIAM HARRISON | | | | | | |
| 6a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b SOCIAL SECURITY NO | | 17. INFORMANT | | | | |
| NO | | | 133-01-4603 | | DAUGHTER Address 12203-BLAXFIELD CT ROCKVILLE MD | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 174X Metastatic Adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Breast DUE TO, OR AS A CONSEQUENCE OF (c) 3 yrs. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mos. | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or RFD No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5 yrs, 1968 to 3/22, 1969, that (I) (we) last saw the deceased alive on 3/20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE G. Lennard Gold MD | | | | | DEGREE ATTENDING PHYS | | MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED 3/22/68 |
| 22d PHYSICIAN'S NAME (Type) G. LENNARD GOLD MD | | | | | 22e ADDRESS 9801-GEORGIA AVE SILVER SPRING MD | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| MAR. 25, 1969 | | | | ARLINGTON NATL CEM | | ARLINGTON V.A. | | | |
| 24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS ADDRESS 3501-14th N.W. WASH. D.C. | | | | | 25a. REC'D BY REG STRAR | | 25b. REG STRAR'S SIGNATURE | | |
| | | | | | MAR 26 1969 | | William J. Jones | | |

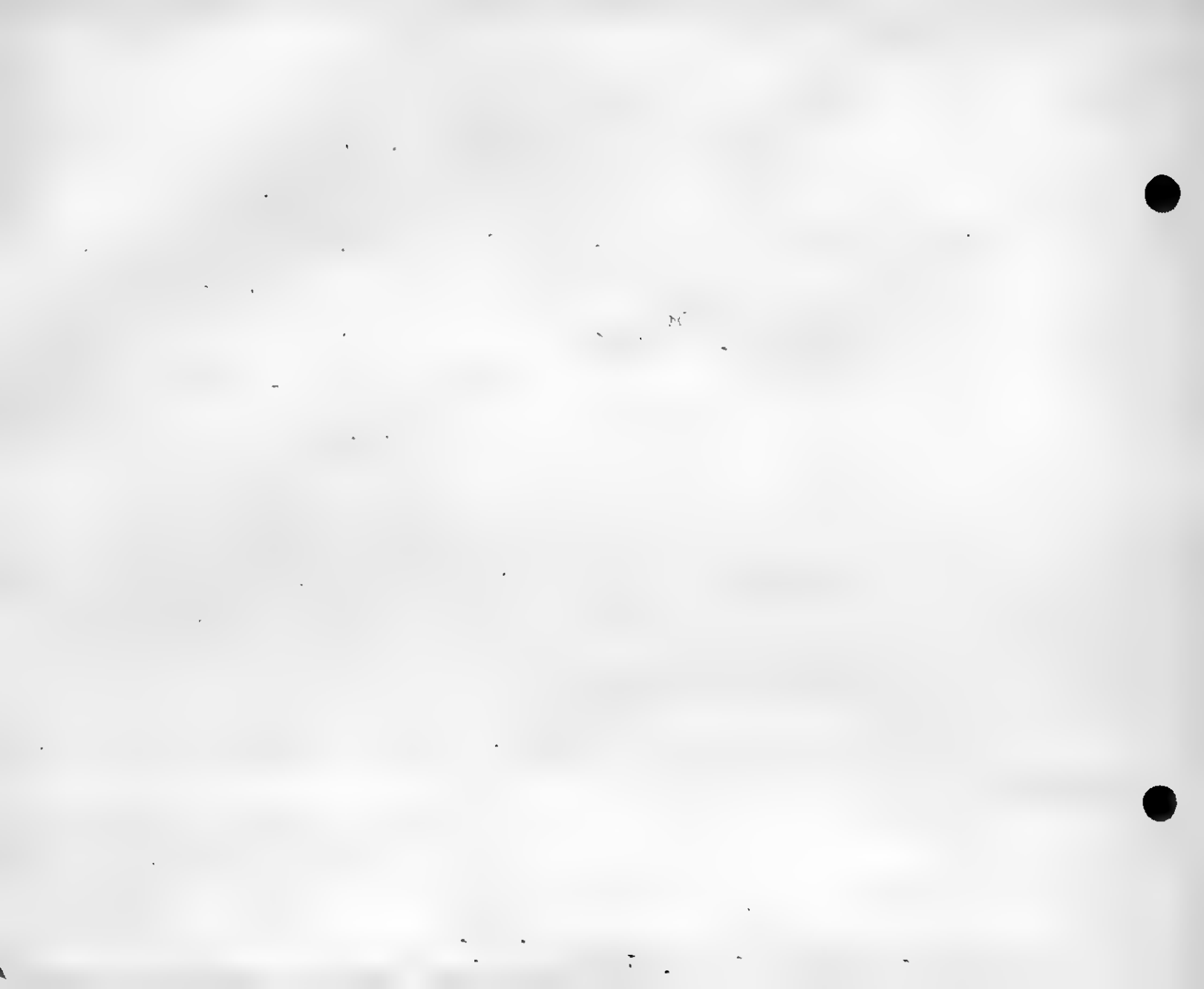
04114

CERTIFICATE OF DEATH

| | | | | | | | |
|---|-----------------|--|-----------------------------------|--|--|---|---------------------|
| 1 DECEASED NAME
(Type or print) | | First
Rebecca | Middle
G | Last
Harvill | 2a DATE OF DEATH
March Month 13 Day 1969 Year | | 2b HOUR
1:30 P M |
| 3 SEX
female | 4 RACE
white | | 5 DATE OF BIRTH
April 12, 1907 | | 6 AGE (in years
last birthday)
61 YRS | 7 UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign
country)
Penna | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital
give street address)
12325 New Hampshire Avenue | | 12a USUAL OCCUPATION (Kind of work done
during most of working life even if retired)
Beautician | | 12b KIND OF BUSINESS OR
INDUSTRY
Beauty Parl. | |
| 13a USUAL RESIDENCE (Where deceased
admission) STATE
Md. | | 13b COUNTY
Montgomery | | 13c CITY OR TOWN
Silver Sp. | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
First Ernest Middle A. Last | | 15 MOTHER'S MAIDEN NAME
First Jennie Middle Last Hanks | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service)
NO | | | |
| 16b SOCIAL SECURITY NO
Yes | | 17 INFORMANT
Nursing Home Records-12325 New Hampshire Av.
Silver Spring, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Bilateral lower lobe pneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
72 hours | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Generalized shunt-like arthritis - severe | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 1958, to March 13, 1969, that (I) (we) last
saw the deceased alive on March 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
Harry N. Carlton, MD | | DEGREE
MD | | ATTENDING
PHYS <input checked="" type="checkbox"/> MED
DIRECTOR <input type="checkbox"/> STAFF
PHYS <input type="checkbox"/> | | 22c DATE SIGNED
March 13, 1969 | |
| 22d. PHYSICIAN'S
NAME (Type)
HARRY N. CARLTON | | 22e ADDRESS
8811 Colesville Rd, Silver Spring, Md. | | | | | |
| 23a BURIAL RECORDS
LOCAL (Specify) | | 23b DATE
Mar 16, 1969 | | 23c NAME OF CEMETERY OR CREMATORY
Everett Cemetery | | 23d LOCATION (City or Town) (County) (State)
Everett Pennsylvania | |
| 24 FUNERAL DIRECTOR
Pumphrey, Inc. 8434 Glen Ave. Sit. Spg. Md. | | ADDRESS
C. Glen Carter | | 25a REC'D BY REG STRAR
DATE
MAR 17 1969 | | 25b REGISTRAR SIGNATURE
Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

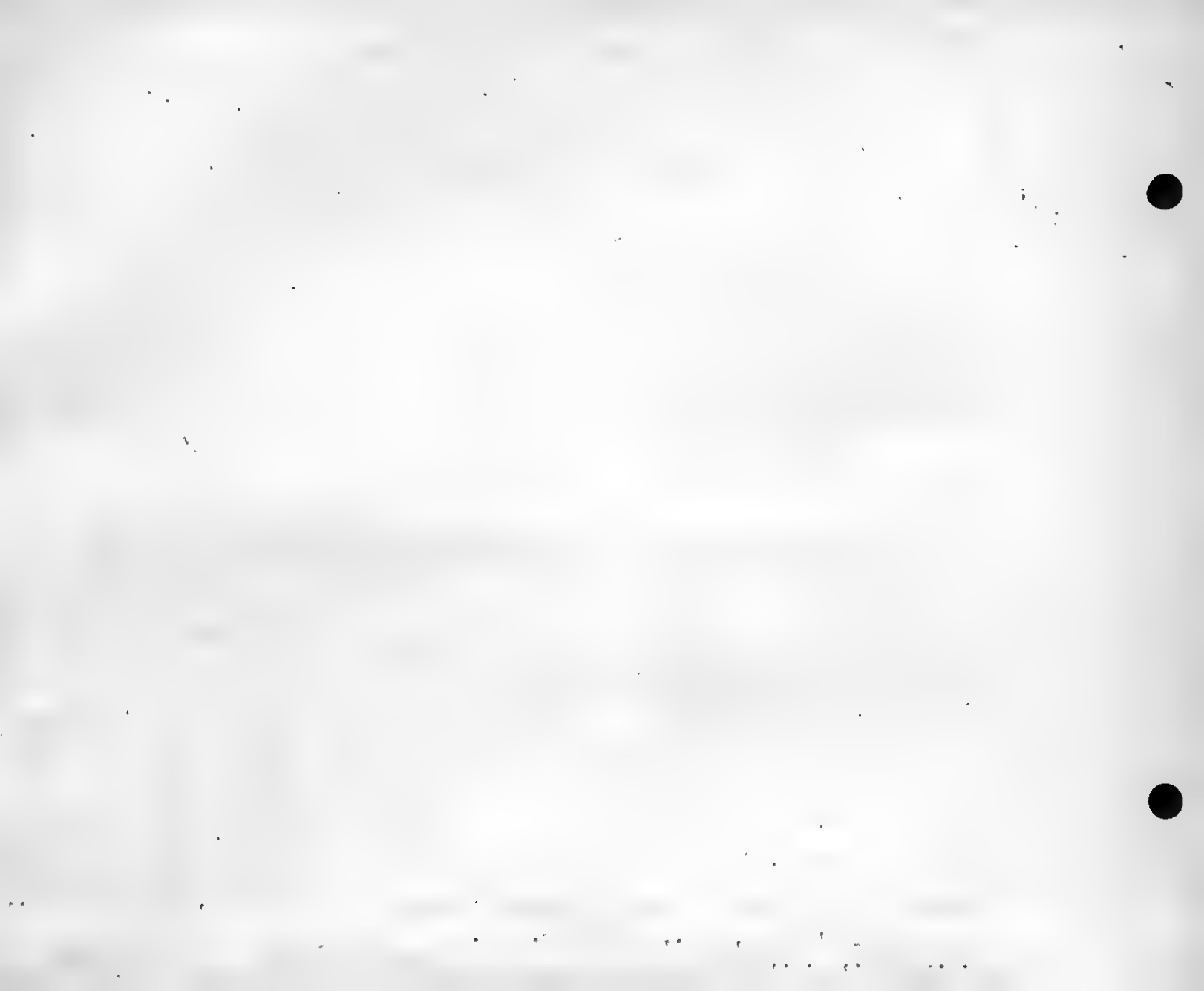


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | 04107 | | | | |
|---|--------|-----------------|--|--------------------------------|-----------------------------------|---|------|-----------------------------|---|---|----------------------------|----------------------------------|---------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or Print) | | | First | | Middle | | Last | | | 2a DATE KNOWN OF DEATH | | 2b HOUR | | |
| Joseph M. Hausler | | | | | | | | | | ESTIMATED <input checked="" type="checkbox"/> 3 28 1969 | | 130 | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c DATE PROMOUNCED DEAD | | 2d HOUR | | |
| M. | W | Jan 15/1980 | | 89 YRS | | MONTHS DAYS | | HOURS MIN | | March Day 28 Year 1969 | | 3 15 PM | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | | | | |
| Michigan | | | U.S.A. | | | | | | Montgomery Md. | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | Westwood Home River Rd. | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | | | |
| D.C. | | | Washington | | | Annapolis | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4600 Connecticut Ave. N.W. | | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S M.A.DEN NAME | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | |
| No | | | 598-46-6537 | | | MR. EUGENE GALLAGHER, NEPHEW | | | FALLS CHURCH, VA | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Asphyxia</u> | | | | | | | | | | 5 min | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | |
| (b) <u>Hanging</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20 AUTOPSY? | | | | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b TIME OF INJURY Month, Day, Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | |
| | | | 130 3-28 1969 | | | Hanging self with rope on remainder | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No | | | City or Town | | County | | State | |
| | | | Nursing Home | | | 5101 Richfield Rd. | | | Bethesda | | Montgomery Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | | | | 22b DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | March 28, 1969 | | | | | |
| John G. Ball | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) | | | (County) | | (State) | |
| Burial | | | 4-1-1969 | | Gate of Heaven Cemetery | | | Silver Spring | | | Montgomery Co., | | Md. | |
| 24 FUNERAL DIRECTOR | | | 25a REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016 | | | DATE APR 7 1969 | | | J. Charles Judge | | | | | | | | |

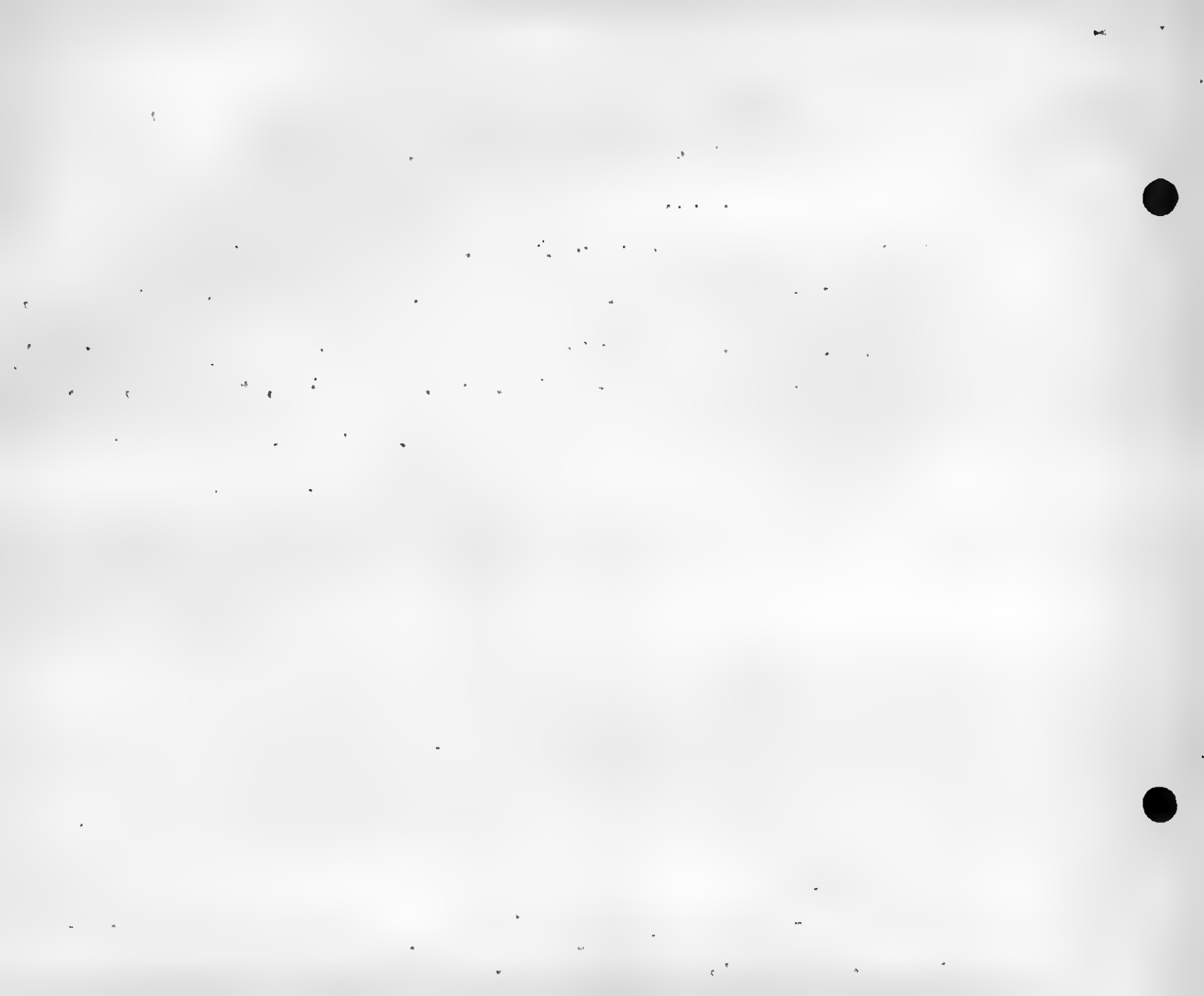


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04116

CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
BLANCHE NUNN HAZZARD | | | 2a. DATE OF DEATH
Month Day Year
March 12, 1969 | | 2b. HOUR
A M |
| 3 SEX
Female | 4 RACE
White | 5. DATE OF BIRTH
July 3, 1891 | | 6 AGE (in years last birthday)
77 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN |
| 7a BIRTHPLACE (State or foreign country)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 COUNTY OF DEATH
Montgomery Md | | |
| 10 CITY OR TOWN OF DEATH
Kensington | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Carroll Hall Nur.Home | 12a USUAL OCCUPATION (Kind of work done during most of work not to even if retired.)
Homemaker | | 12b KIND OF BUSINESS OR INDUSTRY
**** |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b COUNTY
Montg. | 13c CITY OR TOWN
Bethesda | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER
7604 Westfield Drive. |
| 14. FATHER'S NAME First Middle Last
Mercer | | 15. MOTHER'S MAIDEN NAME First Middle Last
Nunn Mollie Dabney | | 7604 Westfield Dr. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO | | 16b SOCIAL SECURITY NO
578-10-5881 | | 17. INFORMANT
D. Mrs. Helen Ake, Bethesda, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u>
DUE TO, OR AS A CONSEQUENCE OF
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arteriosclerotic Cerebral Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 yrs</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Diabetes mellitus</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 16, 1967</u> , to <u>March 12, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Stephen W. DeJeter, M.D.</u> | | 22c. DATE SIGNED
3-12-1969 | | 22d. PHYSICIAN'S NAME (Type)
STEPHEN W DEJETER, M.D. | |
| 22e. ADDRESS
6719 WILSON LANE, BETHESDA, MD. | | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
4-14-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | |
| 23d. LOCATION (City or Town)
Rockville, Montg. | | 23e. (County)
Maryland | | 23f. (State) | |
| 24 FUNERAL DIRECTOR
ROBERT A. PUMPHREY, | | 755 ADDRESS
Bethesda, Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 19 1969 | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04117

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04109

| | | | | | | | | | |
|---|-------------------------|---|--------------------------------------|---|--|---|--|------------------------------|---|
| 1. DECEASED-NAME
(Type or print) BRUCE | | First | Middle | Last | 2a. DATE OF DEATH
Month 3 Day 1 Year 69 | | | 2b. HOUR
8:25 P.M. | |
| 3. SEX
MALE | 4. RACE
WHITE | | 5. DATE OF BIRTH
8-12-1882 | | 6. AGE (In years last birthday)
86 YRS | | IF UNDER YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
W. VA. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASH. SAN. & Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY
retired | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institut on Res dence before admission) STATE
Md. | | 13b. COUNTY
VIRGEE GEORGE ADELPHI | | 13c. CITY OR TOWN
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1814 METZEROTT Rd. | | | |
| 14. FATHER'S NAME
First BENJAMIN Middle HEATER Last ELIZABETH | | 15. MOTHER'S MAIDEN NAME
First ELIZABETH Middle CARPER Last CARPER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown) NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO
- | | 17. INFORMANT
Hospital Records & F.D. Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY
1124 IMMEDIATE CAUSE (a) Coronary Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) last | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 2-19 , 19 67 , to 3-1 , 19 67 , that (I) (we) lost saw the deceased alive on 3-1 , 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Morton Aitschuler M.D. | | DEGREE
ATTENDING PHYS | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
3-1-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Morton Aitschuler, M.D. | | 22e. ADDRESS
9205-New Hampshire Ave. Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE
3/2/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Springhill, | | 23d. LOCATION (City or Town) (County) (State)
Charleston, W.Va. | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons,
5130 Wisconsin Av., NW, Washington, D.C. | | | | 25a. REC'D BY REGISTRAR
MAR 6 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04118

04110

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | |
|--|--------------------------|---|---|---|
| 1. DECEASED NAME
(Type or Print) <i>Russell Watson Henry</i> | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>Mar. 7 1969</i> | | 2b. HOUR <i>5:30 PM</i> |
| 3. SEX <i>M</i> | 4. RACE <i>W</i> | 5. DATE OF BIRTH <i>Mar 15-25 43</i> | 6. AGE (in years last birthday) <i>43</i> YRS | 7. UNDER 24 HRS
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/> |
| 7a. BIRTHPLACE (State or foreign country) <i>No. Carolina</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. COUNTY OF DEATH <i>Montgomery</i> | | 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | |
| 11. NAME OF HOSPITAL, OR INSTITUTION (if not in hospital give street address) <i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Match Maker</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution or residence before death) <i>Maryland</i> | | 13b. CITY OR TOWN <i>Bethesda</i> | | 13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 14. FATHER'S NAME First <i>Russell</i> Middle <i>Watson</i> Last <i>Henry Sr.</i> | | 15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i></i> Last <i></i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i> | | 16b. SOCIAL SECURITY NO <i>246-34-3299</i> | | 17. INFORMANT <i>John G. Ball</i> ADDRESS <i>Same as above</i> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>
412
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
(b) <i>coronary occlusion.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Generalized Arteriosclerosis Severe -</i> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 days</i>
<i>3 days</i>
<i>years</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <i>19</i> P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <i>March 8, 1969</i> |
| EXAMINER'S NAME (Type) <i>John G. Ball</i> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE <i>3/11/69</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Academy Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Asheville, N. C.</i> |
| 24. FUNERAL DIRECTOR <i>Tyson Wheeler F. H.</i> ADDRESS <i>1331 Rockville Pike Rockville, Maryland</i> | | 25a. REC'D BY REGISTRAR <i>MAR 12 1969</i> | | 25b. REGISTRAR'S SIGNATURE |

**FOR STATE
HEALTH DEPT.**

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Items 18a22a Film 411 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
4-24-69 ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04119

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04111

| | | | | | | | | | | | |
|---|--------|-----------------|---|---|--|--|--|---|--|--|---------|
| 1 DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 3-22-1969 | | | 2b HOUR 4:36 PM | | |
| ROBERT LEON HERNDON | | | | | | | | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years lost birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c DATE PRONOUNCED DEAD
Month Day Year | | | 2d HOUR |
| Male | White | 7-14-19 | 49 YRS | | | | | 3-22-1969 | | | 4:36 |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | |
| D.C. | | | USA | | | | | | Montgomery Md | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Takoma Park | | | Wash. San. & Hosp. | | | Sign Painter | | | Dept. of Int | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| Md. | | | P.G. | | | Adelphi | | | 7975 18th Ave. | | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Budd Herndon | | | Grace Horton | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17 INFORMANT | | | ADDRESS | | |
| yes | | | WW 2 | | | Mrs. Mildred Herndon - Wife | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory failure, | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| (b) Etiology undetermined | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 3/22/1969 | | | |
| BELDEN R. REAP, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b DATE | | | | 23c NAME OF CEMETERY OR CREMATORY | | | |
| Burial | | | | MAR 25 1969 | | | | GATE OF HEAVEN | | | |
| 24 FUNERAL DIRECTOR | | | | 23d LOCATION (City or Town) (County) (State) | | | | 25a REC'D BY REGISTRAR | | | |
| | | | | w/len 16 n MD | | | | MAR 26 1969 | | | |
| 25b REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| | | | | | | | | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 2a Film 411
4-7-69 ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04120

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04112

| | | | | | | | | | | | |
|---|---------------------|--|---|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(Type or Print) | | First
ELLEN | | Middle
ELIZABETH | | Last
HINDMAN | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> Month 3- Day 25- Year 1969 | | 2b. HOUR
2:43 PM | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
10-10-14 | 6. AGE (In years last birthday)
54 YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS
HOURS
MIN | | 2c. DATE PRONOUNCED DEAD
Month 3- Day 25 Year 1969 | | 2d. HOUR
2:43 PM | |
| 7a. BIRTHPLACE (State or foreign country)
DC | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | | Md. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington San & Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Private | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE
Md. | | 13b. COUNTY
Pri. Geo. | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
6226 20th Place | | | |
| 14. FATHER'S NAME
First Arthur Middle Deceased Last J. Bugden | | | | 15. MOTHER'S M A DEN NAME
First Marguerite Middle Werten Last Bugden Baker | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
578-10-2608 | | 17. INFORMANT
(Husband)
Robert Wm. J. Hindman | | ADDRESS
6226-20th Pl., Hyattsville | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty metamorphosis of liver, severe
571.6
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE PERIOD BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MED. CAL. EXAM. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
3/25/1969 | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP M.D. | | ADDRESS
4401 E. North Ave., Baltimore | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
March 29, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland Maryland | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | 4834 ADDRESS
Georgia Avenue | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
45M - 1-1969

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|-------------------|---|--|--|--|----------------------------|-------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04121 CERTIFICATE OF DEATH 04113 | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a DATE OF DEATH | | | 2b HOUR |
| SARAH F. HINES | | | | | | Mar. 26, 1969 | | | 2:45 P.M. |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Female | | Cauc. | | Nov. 21, 1885 | | 83 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Illinois | | U. S. | | | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | Carriage Hill Nursing Home | | Retired | | | | | |
| 13a US.A. RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| Maryland | | Montgomery | | Silver Spring | | | | 2100 Belvedere Blvd. | |
| 14 FATHER'S NAME | | | First Middle Last | | | 15 MOTHER'S MAIDEN NAME | | | First Middle Last |
| Frank M. Lloyd | | | | | | Alice Lenore Nichols | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | Address | | | |
| No | | 299-01-6141 | | Alice L. Hines | | Same as Item 13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>long standing pulmonary emboli</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/> of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-4-1964</u> to <u>3-26-1969</u> , that (I) (we) last saw the deceased alive on <u>3-25-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| <u>[Signature]</u> | | MD | | | | <u>3-26-69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| <u>James Berger, M.D.</u> | | <u>800 PERSHING DRIVE SILVER SPRING, MD.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3-29-69 | | Rock Creek Cemetery | | Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | APR 1 1969 | | <u>[Signature]</u> | |



8:15 AM 3/4/69 Case cleared by Dr. Belden
Roap, coroner

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

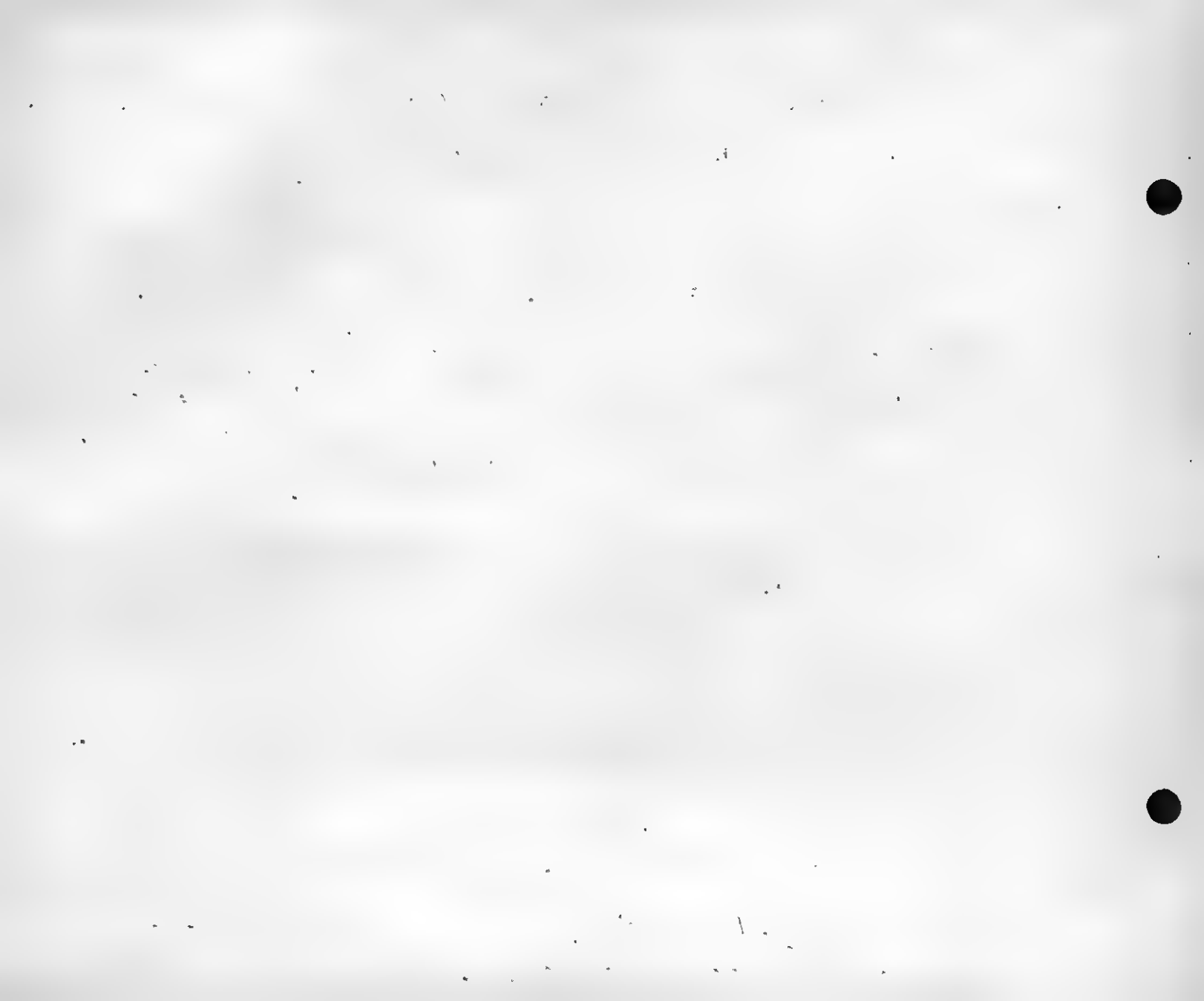
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04122

CERTIFICATE OF DEATH

04114

| | | | | | | | | |
|---|--|---|--------|---|---|---|----------------------|---|
| 1. DECEASED-NAME
(Type or print) HERBERT | | First F | Middle | Last HODGE (JR) | 2a. DATE OF DEATH
3 Month 4 Day 1969 | | 2b. HOUR
4:55 a M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
11/11/23 | | 6. AGE (In years
last birthday)
45 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS M N |
| 7a. BIRTHPLACE (State or foreign
country) D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) HOLY CROSS HOSP. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY
STATE DEPT. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Sil.Spr. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
814 Daleview Drive |
| 14. FATHER'S NAME First Herbert J. Hodge | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME First Mary L. Fergerson | | Middle Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No (If yes give year or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT 814 Daleview Dr.
Mary Ann Hodge Silver Spring, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Acute myocardial infarction, left
4103 DUE TO, OR AS A CONSEQUENCE OF postero-septal
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 DAYS
7 YEARS | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
OBESITY, ENDOGENOUS | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/10 , 19 57 , to 3/4 , 19 69 , that (I) (we) lost saw the deceased alive on 3/4 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE James A. Roberts M.D. | | | | 22c. DATE SIGNED
MARCH 4, 1969 | | | | |
| 22d. PHYSICIAN'S NAME (Type) James A. Roberts, M.D. | | | | 22e. ADDRESS
8907 Georgia Ave., Sil.Spr., Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Mar 6, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | | |
| 24. FUNERAL DIRECTOR
Warner E. Humphrey Inc. 8424 Ga. Ave. Silver Spring, Md. | | | | 25a. REC'D BY REGISTRAR
MARK 7 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04123

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04115

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|------------------------------------|--|
| 1. DECEASED NAME
(Type or print) MARTIN | | First Middle Last | | 2a. DATE OF DEATH
Month Day Year MAR 15 1969 | | | 2b. HOUR
20 M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
JUL 11 1912 | | 6. AGE (In years last birthday)
56 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country)
Germany | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hosp | | | | 12a. USUA. OCCUPAT ON (Kind of work done during most of working life)
Rate Clerk Southern Railway | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUA. RESIDENCE (Where deceased lived if institution: Residence before admission) STATE
DISTRICT of Columbia | | 13b. CITY OR TOWN
Washington | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
1500 MASS AVE NW | | | | | |
| 14. FATHER'S NAME
LOUIS | | First Middle Last | | 15. MOTHER'S MAIDEN NAME
KINA THALHEIMER | | First Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown YES | | 16b. SOCIAL SECURITY NO.
062-10-3721 | | 17. INFORMANT
ERNST HOFMANN | | Address
10113 HEREFORD PL. SIL. SPR. MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardial infarction, primary
DUE TO, OR AS A CONSEQUENCE OF
(c) 10 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year 19
P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC. | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-5 , 19 64 , to 3-15 , 19 69 , that (I) (we) last saw the deceased alive on 3-15 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Morris Perry, M.D. | | DEGREE
M.D. | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-15-69 | |
| 22d. PHYSICIAN'S NAME (Type)
MORRIS PERRY, M.D. | | 22e. ADDRESS
11602 GEORGIA AVE. SIL. SPR. MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3/16/69 | | 23c. NAME OF CEMETERY OR CREMATORY
B'NAI ISRAEL CEM. | | 23d. LOCATION (City or Town) (County) (State)
DXON HILL MD. | | | | | |
| 24. FUNERAL DIRECTOR
GOLDBERG FUNERAL HOME | | ADDRESS
ST. N. 4 | | 25a. REC'D BY REGISTRAR
MAR 18 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

Director, page 3 should be deleted for use as the burial-transit permit. Their please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
FORM REV. 1/68

| <div style="display: flex; justify-content: space-between;"> 04124 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04116 </div> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> | | | | | | | | | |
|--|--|---|------------------------------|--|--|---|--|-----------------------------|--|
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | |
| Fred W Holzberger | | | | | | Month 3 Day 31 Year 69 | | 11:10 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR MONTHS DAYS | |
| Male | | W | | 2-20-1891 | | 78 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Iowa | | | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | H. C. H. | | Supt. Engr. Research | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER | | | |
| Fla. | | W. Palm Beach | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 348 Potter Road. | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S M.A.D.E.N. NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Charles L. Holzberger | | | Katherine D. Piper | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| No | | | 577-09-9282A | | Fred W. Holzberger Jr.-Pl., Hy., Md. | | 4203-74th | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY. | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/23</u> , 19 <u>69</u> , to <u>3/31</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/31</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Dr. Leonard Gray</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>4/1/69</u> | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 4/3/69 | | Mt. Olivet Cem. | | Wash., D.C. | | | |
| 24. FUNERAL DIRECTOR
Nalley's Funeral Home Inc. | | | | | 25. REGISTRAR'S SIGNATURE
Charles Judge | | | | |
| Home Inc. Maryland | | | | | DATE APR 7 1969 | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
|--|--|--|------------------------------|---|--|---|--------------------------------|--|-------------------------|---|-----------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a DATE OF DEATH | | | 2b HOUR | | | | | | |
| MARtha Belle | | | Howell | | | MARCH 21 | | | 1969 1A ¹⁰ M | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | |
| FEMALE | | Cau. | | 9/5/1884 | | | 87 YRS | | MONTHS DAYS | | HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | |
| Kentucky | | | U.S.A. | | | | | | Montgomery | | | Md | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | | | Grosvenor Lane Nursing Home | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE | | | | 13b COUNTY | | | | 13c CITY OR TOWN | | 13d RESIDE CITY, HAS? | | 13e STREET AND NUMBER | | | |
| Maryland | | | | Montgomery | | | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 10224 Hatherleigh Dr. | | | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | | |
| Hugh | | | Warren | | | SUSAN | | | Bell | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b SOCIAL SECURITY NO. | | | | 17 INFORMANT | | | | Address | | | |
| NO | | | | 319-28-63310 | | | | Mrs. Wendall Richards | | | | Bethesda, Md. 10224 Hatherleigh Dr. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Septicemia | | | | | | | | | | | | 4 wks | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) Chronic lymphocytic leukemia | | | | | | | | | | | | 12 years | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| Arteriosclerotic Heart Disease | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | |
| 21d INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) | | | | 21f. LOCATION | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 15, 1963, to March 21, 1969, that (I) (we) last saw the deceased alive on March 20, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | DEGREE | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED | | | |
| Stanley M. Bialek | | | | | | | | | | | | 21 March 69 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e ADDRESS | | | | | | | | | |
| STANLEY M. BIALEK, M.D. | | | | | | 8218 Wisconsin Ave. Beth. Md. | | | | | | | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | 3-24-69 | | Toulon Cemetery | | | | Toulon, Stark Co. Ill. | | | | | | | |
| 24 FUNERAL DIRECTOR | | | | | | ADDRESS | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| Robert A. Pumphrey | | | | | | 7557 Wisconsin Ave | | | | MAR 26 1969 | | J. J. Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|--|---|---|--|-------|--|
| 04126 | | CERTIFICATE OF DEATH | | | | | | 04118 | |
| 1 DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR A.M. |
| John Thorman Hudman | | | | | | March 28 1969 | | | 11:10 A.M. |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | | 6 AGE (In years last birthday) | | 7. IF UNDER 1 YEAR MONTHS DAYS |
| Male | | White | | 5 July 1925 | | | 43 YRS | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Texas | | U.S.A. | | | | | Montgomery Md. | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Bethesda | | | The Clinical Center, NIH | | | Statistician | | | U.S. Govt. |
| 13a. USUAL RESIDENCE (Where deceased lived or admission) STATE | | | 13b. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER |
| Maryland | | | Prince Georges Suitland | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 3204 Ryan Drive |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| John P. Hudman | | | Sarah Thorne | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO | | | 17 INFORMANT The Medical Record Address | | | |
| no | | | 461-22-9335 | | | The Clinical Center, NIH, Bethesda, Md. 20014 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Extensive Visceral Hemorrhage | | | | | | | | | days |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Subdural Hematoma, Bilateral | | | | | | | | | days |
| DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Myelogenous Leukemia | | | | | | | | | 6 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 13 February, 1969, to 28 March, 1969, that (X) (we) last saw the deceased alive on 28 March, 1969, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | |
| Sherrard L. Hayes, M.D. | | | 28 March 1969 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | |
| Sherrard L. Hayes, M.D. | | | The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3-31-1969 | | Kenedy Cemetery | | Kenedy Texas | | | |
| 24 FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| 4308 Suitland Road Suitland Maryland | | | | | DATE APR 1 1969 | | Francis J. Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1-69

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|----------------------|--|-----------------|------------------------------------|---|--------------------------------|---|--|--|--|
| 04127 | | CERTIFICATE OF DEATH | | | | | | 04119 | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Sarah E. Hughes | | | | | | March 6, 1969 | | | 10:00 | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | | 7 UNDER 1 YEAR | | |
| female | | white | | 2/18/84 | | | 85 YRS | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| MASSACHUSETTES | | | U.S.A. | | | | | | Montgomery | | |
| 10. PLACE OF BIRTH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Boston, MA | | | Suburban | | | Teacher | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. HOME CITY TIME ZONE | | |
| MD | | | Montgomery | | | Shirley Chase | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET AND NUMBER | | | | | |
| Evelyn | | | Sarah Elizabeth Davis | | | 5600 Warwick Pl. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| NO | | | 135-32-0153 | | | Mary E. Fitz Gerald | | | As above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma, colon with metastasis | | | | | | | | | | | |
| 1558 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1968 to 3/6 1969, that (I) (we) lost saw the deceased alive on 3/5 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | | | |
| Blaine Fitzgerald M.D. | | | | | | 3/6/69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| J. BLAINE FITZGERALD, M. D. | | | | | | 8218 NISS. AVE. BETHESDA, MARYLAND. | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | | 3-11-69 | | MT. ST. MARY'S CEMETERY | | | PAWTUCKET R. I. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| FRANCIS J. COLLINS | | | | | | MD. | | | R. I. | | |
| 500 UNIVERSITY BLVD. WEST, SILVER SPRING, | | | | | | DATE MAR 12 1969 | | | Charles Judge | | |

MEDICAL CERTIFICATION

04128

CERTIFICATE OF DEATH

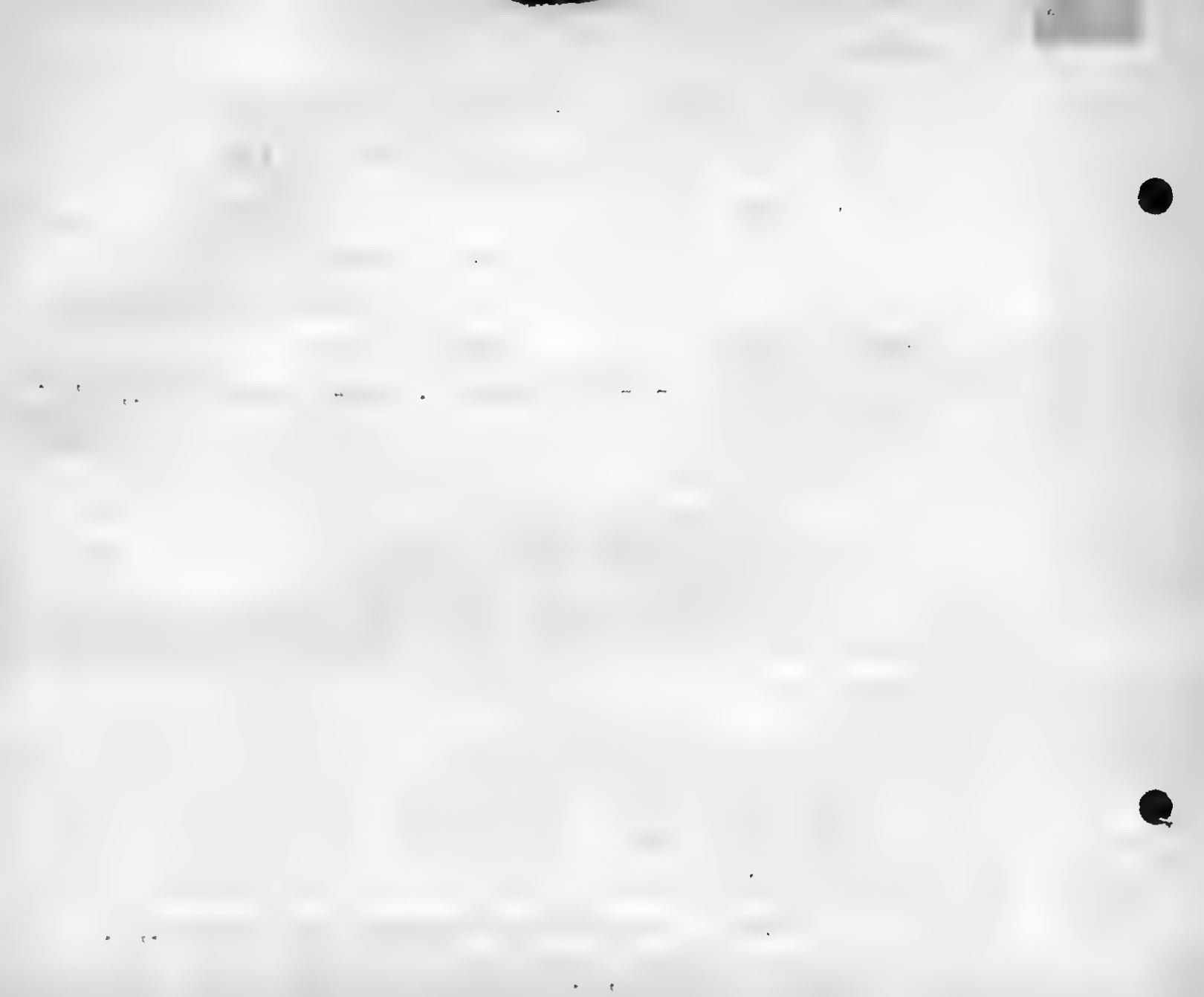
04120

| | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|---|---------------------------|--|
| 1 DECEASED NAME
(Type or print) <i>Pearl</i> | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month <i>March</i> Day <i>17</i> Year <i>1969</i> | | | 2b. HOUR
<i>7:15</i> M | |
| 3 SEX
<i>Female</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
<i>10/9/84</i> | | | | 6 AGE (in years
last birthday)
<i>84</i> | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign
country) <i>Richmond, Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
<i>Montgomery</i> | | | | | | |
| 10 CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital
give street address) <i>Suburban Hosp</i> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution
admission) STATE <i>Md</i> | | 13b. COUNTY <i>Mont</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>222 Blandford Ave</i> | | | | |
| 14 FATHER'S NAME
First <i>Joseph</i> Middle <i>Ellington</i> Last | | 15 MOTHER'S MAIDEN NAME First
<i>Martha</i> Middle <i>Flourney</i> Last | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO
<i>212-52-1579T</i> | | 17 INFORMANT
Address <i>Rockville, Md.</i>
<i>Francis C. Hyman-222 Blandford St.</i> | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY
<i>4339</i> IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>3 weeks</i> | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-25</i> , 19 <i>69</i> , to <i>3-17</i> , 19 <i>69</i> , that (I) (we) last
saw the deceased alive on <i>3-16</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>James W. Egan M.D.</i> | | 22c. DATE SIGNED
<i>3-17-69</i> | | 22d. PHYSICIAN'S
NAME (Type)
<i>James W. Egan</i> | | 22e. ADDRESS
<i>5413 Cedar Lane - 206c Bethesda</i> | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>3/19/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>George Washington Memorial</i> | | 23d. LOCATION (City or Town)
<i>Prince George Co., Md.</i> | | | | | | |
| 24. FUNERAL DIRECTOR
<i>Tyson Wheeler Funeral Home-1331 Rockville Pike</i> | | ADDRESS
<i>Rockville, Md.</i> | | 25. RECD BY REGISTRAR
DATE
<i>MAR 21 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>James Judge</i> | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 04130 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04121 | |
| 1 DECEASED NAME
(Type or print) <i>Edward B. Irwin</i> | | | | 2a DATE OF DEATH
Month <i>3</i> Day <i>15</i> Year <i>69</i> | | 2b HOUR
<i>1:15</i> P.M. | |
| 3 SEX
<i>Male</i> | | 4 RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>9-27-19</i> | | 6 AGE (In years last birthday)
<i>49</i> YRS. | |
| 7a BIRTHPLACE (State or foreign country)
<i>Victor, Iowa</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
<i>Montgomery</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>Driving Instructor</i> | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
<i>Md.</i> | | 13b COUNTY
<i>Montgomery Silver Sp.</i> | | 13d INS DE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e STREET AND NUMBER
<i>12317 Charles Rd.</i> | |
| 14. FATHER'S NAME First Middle Last
<i>Edwin Irwin</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Unknown</i> | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
<i>yes WW 11</i> | | 16b SOCIAL SECURITY NO.
<i>478-05-1851</i> | | 17 INFORMANT Address
<i>Judith A. Irwin- Item # 13</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiovascular collapse</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Hepato failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Cirrhosis of liver</i>
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>renal shutdown</i> | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>March 11, 1969</i> to <i>March 13, 1969</i> , that (I) (we) last saw the deceased alive on <i>March 13, 1969</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
<i>W R Ehrmantrav</i> | | DEGREE
<i>MD</i> | | ATTENDING PHYS
<input checked="" type="checkbox"/> | | MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type) | | <i>W R Ehrmantrav</i> | | 22e. ADDRESS
<i>11125 Rockville Pike</i> | | 22c. DATE SIGNED
<i>3/12/69</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>3/20/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Baltimore National</i> | | 23d. LOCATION (City or town) (County) (State)
<i>Baltimore, Md. 20852</i> | |
| 24. FUNERAL DIRECTOR
<i>Tyson Wheeler Funeral Home-1331 Rockville Pike</i> | | | | ADDRESS
<i>Rockville, Md.</i> | | 25a REC'D BY REGISTRAR
DATE <i>MAR 21 1969</i> | |
| | | | | | | 25b REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|-------------------------|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 04129 | | 04122 | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | First
<i>Howard</i> | | Middle
<i>William</i> | | Last
<i>Jackson</i> | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> Month Day Year
<i>March 16 1969</i> | |
| 3. SEX
<i>Male</i> | 4. RACE
<i>Negro</i> | 5. DATE OF BIRTH
<i>3/23/26</i> | | 6. AGE (In years last birthday)
<i>42</i> YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year
<i>March 16 1969</i> | |
| 7a. BIRTH-PLACE (State or foreign country)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U-S-A</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | | | 12a. USUAL OCCUPATION (Kind of work done, during most of working life, even if retired)
<i>Trash Collector</i> | | 12b. KIND OF BUSINESS OR IND. STRY
<i>Club, Member</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MD</i> | | 13b. COUNTY
<i>Mont</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>10910 Seven Lock Rd.</i> | |
| 14. FATHER'S NAME
First Middle Last
<i>John Wesley Jackson</i> | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Mary James</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
<i>No</i> | | 16b. SOCIAL SECURITY NO
(If yes give year or dates of service) | | 17. INFORMANT
<i>Matthew - Mary Jackson</i> | | ADDRESS <i>Same as above</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Massive hemorrhage, lung and mediastinum</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. }
(b) <i>Knife wound of neck (left side)</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>15 1/2 hr</i>
<i>15 1/2 hr</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR AM PM
<i>11 P.M. 3/15 1969</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<i>Struck on neck during fight with wife</i> | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
<i>Home</i> | | 21f. LOCATION Street or RFD No
<i>703 Lenmore Ave</i> | | City or Town
<i>Rockville</i> | | County
<i>Montgomery</i> | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
<i>John B. Bell</i> | | EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | | | ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED
<i>March 16, 1969</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>3-21-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Lincoln Park Cem.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Rockville Montg Md.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Robert L. Snowden</i> | | ADDRESS
<i>Rockville Md.</i> | | 25a. REC'D BY REGISTRAR
DATE
<i>MAR 26 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

4 22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Revised to H.C. 1967

| 04131 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04125 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print) | | | | | | | | | | 2a DATE OF DEATH | | | | | | | | | | 2b HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Alberta Middle P. Last Johnson | | | | | | | | | | 3 Month 21 Day 69 Year | | | | | | | | | | 2:55a | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Female | | | | | | | | | | 4. RACE Negro | | | | | | | | | | 5. DATE OF BIRTH Sept. 15, 1877 | | | | | | | | | | 6 AGE (In years last birthday) 91 YRS | | | | | | | | | | 7 UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Montgomery Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Brinklow | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | | | | | | | | 13b. COUNTY Montgomery | | | | | | | | | | 13c. CITY OR TOWN Brinklow | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 12635 Brooke Road | | | | | | | | | | | | | | | | | | | |
| 14 FATHER'S NAME First Isaac Middle Smith Last | | | | | | | | | | 15 MOTHER'S MAIDEN NAME First Minnie Middle ? Last | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17 INFORMANT Hallie Williams: Sligo Mill Rd. Takoma Park, Md. | | | | | | | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) | | | | | | | | | | PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL DISEASE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS | | | | | | | | | | YES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS | | | | | | | | | | YES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | CONGESTIVE HEART FAILURE: CHRONIC RENAL DISEASE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 1969 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY OFFICE BUILDING, ETC) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct. 1969, to 3/21, 1969, that (I) (we) lost saw the deceased alive on 3/26 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d.d.) (d.d not) view the body after death. | | | | | | | | | | 22b. SIGNATURE Donald P. Lewis M.D. DEGREE | | | | | | | | | | 22c. DATE SIGNED 3-21-69. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Donald Lewis | | | | | | | | | | 22e. ADDRESS 700 Cloverly St. SIL. SPRING MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | | | | | | | | 23b. DATE 3-25-69 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Church Cemetery, | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Sandy Spring, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Robert J. Sauer Sr. | | | | | | | | | | ADDRESS Rockville, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR MAR 28 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04132

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04126

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1 DECEASED-NAME
(Type or print) Estelle | | First | | Middle | | Last | | 2a. DATE OF DEATH
3 Month 8 Day 69 Year | | 2b. HOUR
2:45 AM | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
3-20-1909 | | 6. AGE (In years last birthday)
59 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
S.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
University Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Caterer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE
D.C. | | 13b. COUNTY
13 | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4928 7th St., NW | | | |
| 14. FATHER'S NAME
Burkley | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME
Estelle | | First Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO.
220-38-2777 | | 17. INFORMANT
MR. JAMES JOHNSON | | Address
4928 7th St. N.W. D.C. | | | | | |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the breast with disseminated metastases
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/20 , 19 67 , to 3/8 , 19 69 , that (I) (we) last saw the deceased alive on 3/8 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE
Myron L. Lenkin | | DEGREE
MD | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/8/69 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Myron L. Lenkin | | 22e. ADDRESS
2309 Shorefield Rd., Wheaton, Md. | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE
3-12-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Mem. Park | | 23d. LOCATION (City or Town) (County) (State)
LANDOVER Prince Geo. Md. | | | | | |
| 24. FUNERAL DIRECTOR
Hall Bros. Opt 621 Fla. Ave NW | | ADDRESS | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04133

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04127

| | | | | | | | | | | |
|---|--------|--|---|---|---|---|-----------------|---------------------------|----------------------------------|-------------------|
| 1 DECEASED NAME
(Type or Print) | | First | Middle | Last | 2a DATE KNOWN OF DEATH | | Month | Day | Year | 2b HOUR |
| Mary A. Johnson | | | | | MATED <input checked="" type="checkbox"/> ESTI <input type="checkbox"/> | | 3 | 4 | 69 | M |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6 AGE (in years - M - D) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | |
| Female | White | 6-15-13 | | 55 YRS | MONTHS DAYS | | HOURS MIN. | | 3 - 4 | Year 69 3:30 P.M. |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF U.S. or FOREIGN COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Penn. | | U.S.A. | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | | 8818 Glenville Rd. | | | Housewife | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if not institution - Residence before admission) STATE | | 13b. COUNTY | | 13c CITY OR TOWN | | 3d INSIDE CITY (A.M. 15?) | | 13e. STREET AND NUMBER | | |
| Md. | | Montgomery | | Sil. Spr. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8818 Glenville Rd. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Frank 01a | | | Mary | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | ADDRESS | |
| no | | | 579-10-40324A | | | Patricia Kinsey | | | Same as # 13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | | | | | | |
| 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | |
| 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| | | | HOUR A.M. P.M. 19 | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b DATE SIGNED | | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | March 4, 1969 | | | | |
| Belden R. Reap M.D. | | | ADDRESS (Street, City, State, or County) | | | | | | | |
| 23b BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) |
| Burial | | 3-6-69 | | Arlington National | | Arlington | | Virginia | | |
| 24 FUNERAL DIRECTOR Francis J. Collins | | | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | |
| 500 University Blvd. W. Sil. Sp. Maryland | | | | | | DATE MAR 10 1969 | | Charles Judge | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

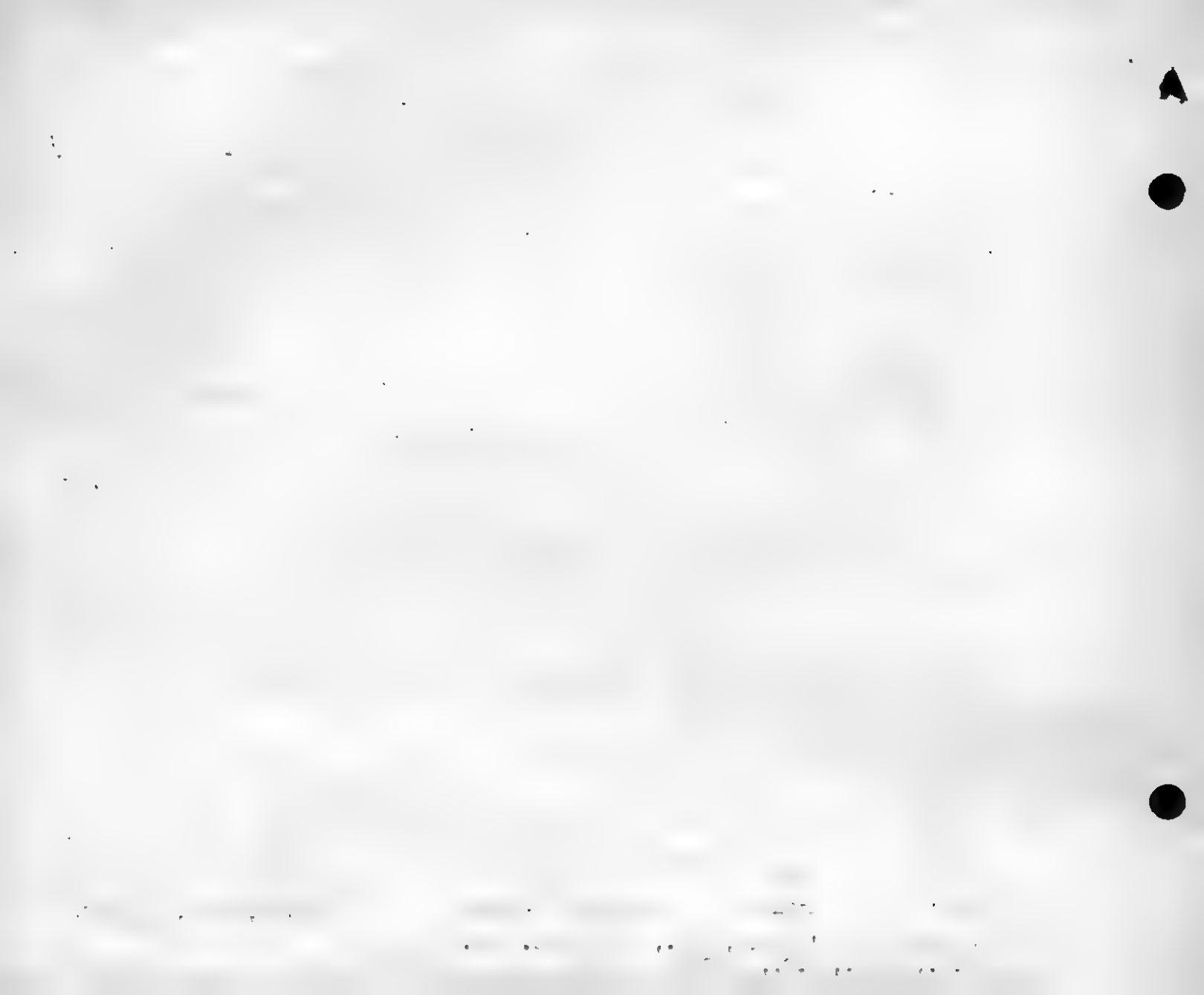
04134

04128

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|-----------------------------|---|---|---|---|--|---|
| 1 DECEASED NAME
(Type or Print) | | First | Middle | Last | 2a DATE KNOWN OF EST. DEATH MATED <input type="checkbox"/> Month Day Year <input checked="" type="checkbox"/> 3 15 1969 | | 2b HOUR 1 15 M |
| 3 SEX | 4 RACE | DATE OF BIRTH | | 6 AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN | 2c DATE PRONOUNCED DEAD Month Day Year 3 15 1969 |
| male | white | 9-15-1922 | | 46 YRS | | | 2d HOUR 1 15 M |
| 7a BIRTHPLACE (State or foreign country) | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | MD |
| Penn. | U.S.A. | | | | Montgomery | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in home give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Gaithersburg | | Washingtonia Golf & Country | | PRINTER | | PRIVATE INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | Mont. | | Bethesda | | 6313-Barnick Lane | |
| 14 FATHER'S NAME | | First | Middle | Last | 15 MOTHER'S MAIDEN NAME | | First Middle Last |
| FRANCIS | | JOHNSTON | | | | SAYLOR | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | |
| YES | | 181-12-5100 | | CLAIRE D. JOHNSON, WIDOW | | SAME AS #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarct, acute
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hrs. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No | | City or Town County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | John S. Ball | | MD | | 22b. DATE SIGNED March 16, 1969 | |
| EXAMINER'S NAME (Type) | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | |
| Burial | | 3-18-1969 | | Arlington National | | Arlington County, Virginia | |
| 24. FUNERAL DIRECTOR | | | | 25a REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016 | | | | DATE MAR 20 1969 | | [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
30M REV 11-68

| MONTGOMERY STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|-------------------------|--|--|---|--|-------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04135 | | | | | | | | | |
| 04123 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR |
| Baby | | | Boy | | Johns | March 1 1969 | | | 8:47A |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | White | | March 1, 1969 | | YRS | | MONTHS | DAYS |
| | | | | | | | | IF UNDER 24 HRS. | |
| | | | | | | | | HOURS MIN | |
| | | | | | | | | 24 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | United States | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | Holy Cross Hospital | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIM. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Montgomery | | Kensington | | | | 11332 Mitscher Street | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| William E | | | | | Johns | Jeanne | | | Johnson |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | |
| Yes, no, or (unknown) | | | | | Father | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity First Twin | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 1, 1969, to March 1, 1969, that (I) (we) last saw the deceased alive on March 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED |
| T.A. Cootner | | | | | | | | | 2 March 69 |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| T.A. Cootner | | | | | 344 Union Blvd W, Sp. Md | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | 23e. REC'D BY REGISTRAR | |
| Cremation | | 3/3/69 | | Cedar Hill | | Prince George Co. Md. | | | |
| 24. FUNERAL DIRECTOR | | 1331 Rockville Pike | | 25a. REGISTRAR'S SIGNATURE | | 25b. REGISTRAR'S SIGNATURE | | | |
| Tyson Wheeler | | Rockville, Maryland | | MAR 4 1969 | | Johns | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
|---|--|--|---|--|--------|---|--|--|---|--|----------|--|--|------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | | | | |
| BABY | | | Boy | | Johns | | March | | 1 | | 9:45 A M | | | | |
| 3 SEX | | | 4 RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| Male | | | White | | | March 1, 1969 | | | YRS | | | 1 | | 22 | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | | | | | |
| Maryland | | | United States | | | | | | Montgomery | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | | Holy Cross Hospital | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c CITY OR TOWN | | | 13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET AND NUMBER | | | |
| Maryland | | | Montgomery | | | Kensington | | | YES | | | 11332 Mitscher Street | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | | |
| William E. | | | Johns | | Jeanne | | Johnson | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | | | | | |
| Yes, no, or unknown | | | | | | Father | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity Twin | | | | | | | | | | | | | | | |
| 777X DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21a INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f LOCATION Street or R.F.D. No. | | | City or Town | | County State | | | |
| 22a I certify that (I) (this hospital) attended the deceased from March 1, 1969, to March 1, 1969, that (I) (we) last saw the deceased alive on March 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | | | | | | | 22c DATE SIGNED | | | |
| T.A. Cook, M.D. | | | | | | | | | | | | 2 March 69 | | | |
| 22d PHYSICIAN'S NAME (Type) | | | 22e ADDRESS | | | | 22f ADDRESS | | | | | | | | |
| T.A. Cook, M.D. | | | 344 Union Berlin St. Md. | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, or other disposition | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) | | | County State | | | |
| Cremation | | | 3/3/69 | | | Cedar Hill | | | Prince George Co. | | | Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| Lyon Wheeler | | | | | | | | | | | | MAR 4 1969 | | Charles Judge | |
| Funeral Home 1551 Rock Pike | | | | | | | | | | | | | | | |
| Rockville, Maryland | | | | | | | | | | | | | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 5, 6, 14 & 15

File # 410 3/17/68 kl

04137

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04129

| | | | | |
|---|--|---|---|--|
| 1. DECEASED NAME
(Type or Print)
Florence Elizabeth Jones | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month 3 Day 8 Year 1969 | | 2b. HOUR
1:15 M |
| 3 SEX
Female | 4. RACE
Cauc | 5. DATE OF BIRTH
12/23/1902 | 6. AGE (in years last birthday)
66 YRS | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) |
| 13a. USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE
Md. | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME First Middle Last
John Sam Samuel Boswell | | 15. MOTHER'S MAIDEN NAME First Middle Last
Bertha Elizabeth Hamilton | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
577-20-6593 | 17. INFORMANT ADDRESS
Betty Villiotti 11526 Soward D. Whea | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
4123
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Coronary Artery Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or RFD No _____ City or Town _____ County _____ State _____ | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE
Belden R. Keap | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
March 8, 1968 |
| EXAMINER'S NAME (Type)
BELDEN R. KEAP, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (City, Town, or County)
Montgomery, Md. |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
March 11, 1969 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia | |
| 24. FUNERAL DIRECTOR
Francis J. Collins | | ADDRESS
500 University Blvd. W. Silver Spring, Md. | | 25. RECEIVED BY REGISTRAR
MAR 12 1969 |
| | | | | 25b. REGISTRAR'S SIGNATURE
Wm. J. J. J. |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04138

04130

| | | | | | |
|--|---|--|---|---|--|
| 1 DECEASED NAME
(Type or print) <i>Sophie Ann Kasmir</i> | | | 2a DATE OF DEATH
Month <i>3</i> Day <i>15</i> Year <i>1969</i> | | 2b HOUR
<i>11:35 PM</i> |
| 3 SEX
<i>Female</i> | 4 RACE
<i>Cauc.</i> | 5 DATE OF BIRTH
<i>6-30-1892</i> | | 6 AGE (In years
last birthday)
<i>76</i> YRS | IF UNDER 1 YEAR
MONTHS
DAYS
HOURS
MIN. |
| 7a BIRTHPLACE (State or foreign
country)
<i>Russia</i> | 7b CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<i>Montgomery</i> | | |
| 10 CITY OR TOWN OF DEATH
<i>Wheaton, Md.</i> | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Nursing Home</i> | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived; if institution: Residence before
admission) STATE
<i>DC</i> | 13b. COUNTY
<i>Wash</i> | 13c CITY OR TOWN
<i>DC</i> | 13d INSIDE CITY - YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER
<i>#201 Cathedral Ave N.W.</i> | |
| 14 FATHER'S NAME
First <i>OSCAR</i> Middle <i>SCHWARTZ</i> Last <i>UNKNOWN</i> | 15 MOTHER'S MAIDEN NAME First <i>UNKNOWN</i> Middle <i>UNKNOWN</i> Last <i>UNKNOWN</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.
<i>0-88-20-7793</i> | 17 INFORMANT
<i>Sidney Kasmir</i> | | Address
<i>4201 Cathedral Ave., N.W.
Washington, D. C.</i> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i>
<i>4123</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a) (b) <i>Generalized arteriosclerosis</i>
stating the underlying cause lost. (c)
DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>4 YRS.</i> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Cerebral Sclerosis - Compression of Lumbar Vertebrae</i> | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B) | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC) | 21f. LOCATION Street or R.F.D. No | City or Town | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/13</i> , 19 <i>68</i> , to <i>4/15/1968</i> , that (I) (we) lost
saw the deceased alive on <i>3/13</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death | | | | | |
| 22b. SIGNATURE
<i>R.T. Benack MD</i> | | DEGREE | ATTENDING
PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS <input type="checkbox"/> | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S
NAME (Type) <i>R.T. Benack MD, M. White MD</i> | | 22e. ADDRESS
<i>415 Colie Dr. Wheaton, MD</i> | | | |
| 23a BURIAL, CREMATION,
REMOVAL (Specify) | 23b. DATE
<i>Apr. 2, 1969</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>King David Memorial Garden</i> | | 23d. LOCATION (City or Town) | (County) (State) |
| 24. FUNERAL DIRECTOR
<i>Donald M. Stein</i> | | ADDRESS
<i>232 Carroll</i> | | 25a. REC'D BY REGISTRAR
<i>APR 7 1969</i> | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |
| <i>Hebrew Memorial Funeral Home St., N.W. Wash., D.C.</i> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | |
|--|--|----------------------|--|--|--------|---|-------|--|---|-------------------|--|--|--|-----------------|--|--|
| 04139 | | CERTIFICATE OF DEATH | | | | | | | | 04131 | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| Mary | | | E. | | Kelly | | March | | | Month 28 Day 1969 | | Year | | | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | 6 AGE (in years last birthday) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| Female | | | White | | | 11-12-78 | | | 90 | | | MONTHS | | DAYS | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | |
| Kansas | | | U.S.A. | | | | | | Montgomery | | | | | Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Kensington | | | 11006 Newport Mill Rd. | | | Retired | | | U.S. Gov. | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | | | | |
| Maryland | | | Montgomery | | | Kensington | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 11006 Newport Mill Rd. | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | | | |
| Amos | | | Pruitt | | | Caroline | | | Bare | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | | | | | | |
| | | | 217-46-5802 | | | Mrs. Cathrine O'Connor | | | Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> | | | | | | | | | | | | 4-5-69 | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | |
| (b) <u>Chronic obstructive heart disease</u> | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | |
| <u>None</u> | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| | | | HOUR A.M. Month Day Year | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | Street or R.F.D. No. | | | City or Town | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 28, 1969</u> , to <u>March 19, 1969</u> , that (I) (we) lost saw the deceased alive on <u>March 28, 1969</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS. | | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | |
| <u>Ralph E. Tatter</u> | | | | | | <input checked="" type="checkbox"/> | | | | | | <u>3/28/69</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | | |
| RALPH E. TATTER | | | 1405 Woodside Park | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | | (County) (State) | | | | |
| Burial | | | 3-31-69 | | | Fort Lincoln | | | Bladensburg, Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Francis J. Collins | | | 500 University Blvd. W. | | | DATE APR 1 1969 | | | <u>[Signature]</u> | | | | | | | |
| | | | Silver Spring, MD. | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|---|---|-----------------------------------|----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04140 | | | | | | | | | |
| 04132 | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| ADA | | | KEMPER | | | MARCH 23 Day 69 Year | | 2:00 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| F | | NEGRO | | 9-1-86 | | 82 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| ARLINGTON Va | | | U.S.A. | | | | MONTGOMERY Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| WHEATON | | | UNIVERSITY NURSING HOME | | | DOMESTIC | | | |
| 13a. USUAL RESIDENCE (Where deceased lived/ if institution. Residence before admission) STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| D.C. | | | 136 COUNTY | | | | 909 R St. N.W. WASHINGTON | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| | | | | | MR. A. GRANT | | 909 R St. N.W. WASHINGTON D.C. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY. | | | | | | | | | |
| IMMEDIATE CAUSE (a) Metastatic CA of R. BREAST | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/13, 1969, to 3/23, 1969, that (I) (we) last saw the deceased alive on 3/16, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED |
| | | | | | | | | | 3/23/69 |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| | | 3-29-69 | | Harmony Memorial Br. Soc. Cemetery Md | | | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Lafayette Funeral Home | | | | | 3831 So ave NW. | | MAR 27 1969 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 04141 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04133 | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME (Type or print) | | | | | | | | | | 2a DATE OF DEATH | | | | | | | | | | 2b HOUR | | | | | | | | | | | | | | | | | | | |
| First Middle Last
Michelle Rene KENT | | | | | | | | | | March 25 69 | | | | | | | | | | 1055 M | | | | | | | | | | | | | | | | | | | |
| 3 SEX
Female | | | | | | | | | | 4 RACE
Caucasian | | | | | | | | | | 5. DATE OF BIRTH
March 13, 1969 | | | | | | | | | | 6. AGE (In years last birthday)
YRS. MONTHS DAYS
12 | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
S. Carolina | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9 COUNTY OF DEATH
Montgomery Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | | | | | | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
N/A | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived or admission) STATE
S. Carolina | | | | | | | | | | 13b. CITY OR TOWN
Charleston | | | | | | | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13d. STREET AND NUMBER
1924 B Mosstree Road | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Michael B. Kent | | | | | | | | | | 15. MOTHER'S MA DEN NAME First Middle Last
Shirley Tilson | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)
N/A | | | | | | | | | | 16b. SOCIAL SECURITY NO.
N/A | | | | | | | | | |
| 17 INFORMANT
Charles S. Carolina | | | | | | | | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAL ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGENITAL HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Mar. 22</u> , 19 <u>69</u> , to <u>Mar. 25</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>Mar. 25</u> , 19 <u>69</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>J. K. Howe M.D.</i> | | | | | | | | | | 22c. DATE SIGNED
Mar. 26, 1969 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
J. K. Howe, M.D. | | | | | | | | | | 22e. ADDRESS
Naval Hospital, Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. B. RIAL, CREMAT OR
Burial | | | | | | | | | | 23b. DATE
3-27-69 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Beaufort National Cemetery Beaufort S.C. | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Robert A. Humphrey | | | | | | | | | | 25a. RECD BY REGISTRAR
APR 1 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>William J. [Signature]</i> | | | | | | | | | | | | | | | | | | | |
| 7557 Wisconsin Ave. Bethesda, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
Cleared with Medical Examiner of Maryland 3/15/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--------|-----------------------------|---|--|-----------------------------------|--|--|---|---------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | | First | Middle | Last | 2a DATE OF DEATH | | 2b HOUR | |
| David | | | none | King | March 15 1969 | | 8:45 AM | | |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | IF UNDER YEAR MONTHS | IF UNDER 24 HRS HOURS | IF UNDER 24 HRS MIN |
| Male | Negro | | Separate 8/20/1901 | | | 67 YRS. | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Oklahoma | | USA | | | | Montgomery Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Wheaton | | | Univ. Nurs. Home | | | Custodian | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b CITY OR TOWN | | | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| Washington, DC | | | 136 COUNTY | | | | | 115 W St., NW | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15 MOTHER'S M.A.D.E.N. NAME | | | First Middle Last |
| Lawrence ? | | | King | Emma | ? | | | | ? |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT Address | | | |
| no | | | 718-12-2042A | | | George Timme 901 Arcola Ave. Wheaton | | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY. | | | | | | | | | |
| IMMEDIATE CAUSE (a) CVA | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, not by medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/5, 1969, to 3/13, 1969, that (I) (we) last saw the deceased alive on 3/13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | | | | | DEGREE | | 22c DATE SIGNED | |
| Allan Cohan, M.D. | | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 3/13/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e ADDRESS | | | |
| Allan Cohan, M.D. | | | | | | 13515 Georgia Ave., Silver Spring, Md. | | | |
| 23a (BURIAL, CREMATION, REMOVAL) (Specify) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | |
| 3-24-69 | | | 3-24-69 | | Harmony | | Landover, Maryland | | |
| 24 FUNERAL HOME | | | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| ROLLINS FUNERAL HOME, INC. | | | | | | DATE MAR 24 1969 | | Judge | |
| 4339 HUNT PLACE, N.E. | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Clear with Medical Examiner

04143

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04135

| | | | | | | | | | |
|--|------------------|--|------------------|---|---|--|---|---|--|
| 1. DECEASED NAME
(Type or print) | | First
MAYNARD | Middle
WILSON | Last
KING | 2a. DATE OF DEATH
Month Day Year
3 27 69 | | 2b. HOUR
12 noon | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
March 11/03 | | | 6. AGE (In years
last birthday)
66 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
salesman | | 12b. KIND OF BUSINESS OR
INDUSTRY
realestate | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sil. Sprg. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
1809 Powder Mill Rd. SSMD | | | |
| 14. FATHER'S NAME
First Middle Last
James R. King | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Della King Woodfield | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
no | | 16b. SOCIAL SECURITY NO.
(If give war or dates of service)
578-50-6548 | | 17. INFORMANT
E. King
wife Ruth 1809 Powder Mill Rd. SSMD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arterio sclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Immed.
years. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Jan 1969 to Mar 1969, that (1) (we) last
saw the deceased alive on Mar 1969, and that in (1) (our) opinion death occurred on the date and hour and from the
causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James R Coleman MD | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
MARCH 27, 1969 | | | |
| 22d. PHYSICIAN'S
NAME (Type)
JAMES R COLEMAN | | 22e. ADDRESS
9241 COLUMBIA BLVD | | SILVER SPRING, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
March 31, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR
S. S. Smith | | 24b. ADDRESS
434 Georgia Avenue | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE
James R Coleman | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial transit permit. Then, please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|
| 04144 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04136 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) Emma Marie Klagey | | | | | | | | | | 2a. DATE OF DEATH 3 Month 3 Day 69 Year | | | | | | | | | | 2b. HOUR 4 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 SEX Female | | | | | | | | | | 4. RACE CAUCASIAN | | | | | | | | | | 5 DATE OF BIRTH 3/11/81 | | | | | | | | | | 6 AGE (In years last birthday) 87 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS HOURS MIN | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) MICHIGAN | | | | | | | | | | 7b CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH MONTGOMERY Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH TAKOMA PARK | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. & HOSP. | | | | | | | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) GOV'T WORKER | | | | | | | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution) STATE M.D. COUNTY PRINCE GEORGES | | | | | | | | | | 13b CITY OR TOWN WASHINGTON | | | | | | | | | | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e STREET AND NUMBER 1316 27TH ST. N.W. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 FATHER'S NAME First CHRISTIAN Middle Last KLAGER | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Louise Middle Last REICHERT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) NO (If yes give war or dates of service) | | | | | | | | | | 16b SOCIAL SECURITY NO 579-60-1008 | | | | | | | | | | 7 INFORMANT HOSPITAL RECORDS | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE | | | | | | | | | | (b) DUE TO, OR AS A CONSEQUENCE OF Massive Cerebral Vascular Thrombosis | | | | | | | | | | 72 hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | (c) DUE TO, OR AS A CONSEQUENCE OF Cerebral Arteriosclerosis | | | | | | | | | | years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 15, 19 69, to March 3, 19 69, that (I) (we) lost saw the deceased alive on March 3, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE Harold W. Draper M.D. | | | | | | | | | | DEGREE | | | | | | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c DATE SIGNED 3 March 69 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b PHYSICIAN'S NAME (Type) HAROLD W. DRAPER M.D. | | | | | | | | | | 22e ADDRESS 9801 GEORGIA AVE; Silver Spring, Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | | | | | | | | | 23b DATE 3-6-1969 | | | | | | | | | | 23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY | | | | | | | | | | 23d LOCATION (City or Town) (County) (State) SEITZLAND PRINCE GEORGES CO. MD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Joseph Lukowicz | | | | | | | | | | ADDRESS WASH., D.C. 5130 Wisconsin Ave | | | | | | | | | | 25a REC'D BY REG STRAR DATE MAR 10 1969 | | | | | | | | | | 25b REG STRAR'S SIGNATURE J Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|---|--|---|---|---|-----------------------|--|
| 04145 | | CERTIFICATE OF DEATH | | | | | | 04137 | |
| 1 DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Helen Stratton Klein | | | | | | Month Day Year
3 8 69 | | | 845 PM |
| 3. SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 UNDER 1 YEAR | |
| Female | | Caucasian | | Mar. 22, 1897 | | 71 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Colorado | | U.S. A. | | | | Montgomery Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY |
| Silver Spring | | | Althea Woodland
Mrs. Home - 1000 Daleview Dr. | | | AT HOME | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER |
| Washington, D.C. | | | | | Washington DC | | | | 4000 Cathedral Ave., N.W. |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last
Chester E. Stratton | | | First Middle Last
Jane F. Walter | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | | | Gen. John A. Klein, HUSBAND, | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive Vascular Disease | | | | | | | | | |
| DUE TO OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or RFD No | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 27, 1967, to Mar 8, 1969, that (I) (we) lost saw the deceased alive on Mar 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | 22c DATE SIGNED | | | | | | | |
| Bernard A. Fitzgerald | | 3-8-69 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e ADDRESS | | | | | |
| BERNARD A. FITZGERALD | | | | 217 New Blad E Bloo. N. Ind | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 3-12-1969 | | ARLINGTON NATIONAL | | ARLINGTON COUNTY, VIRGINIA | | | |
| 24 FUNERAL DIRECTOR | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| Joseph Luciano Sans, 5130 Wino. Ave. | | | | MAR 14 1969 | | Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--------------|--|--|---|-----------------|--|-----------------|--------------------------|------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 04146 | | 04138 | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Robert Middle F. Last Klepinger | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Robert F. Klepinger | | | March 24, 1969 | | | 7:17 | | | M |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6 AGE (in years last birthday) | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS | | |
| Male | White | Aug 12, 1903 | | 65 | MONTHS | | DAYS | HOURS | MIN |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Ohio | | U.S.A. | | | | Montgomery | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | 12a USJA OCCUPATION (Kind of work done during most of working life even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | Suburban | | Attorney | | Law | | | |
| 13a USJA RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| Maryland | | Montgomery | | Bethesda | | | | 7609 Warbury Road | |
| 14 FATHER'S NAME First Middle Last | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Carson W. Klepinger | | | Bessie Jenner | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | | |
| No | | 044-22-9846 | | Mona A. Klepinger, Widow | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY ARTERY disease | | | | | | | | | |
| 4123 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic C.V. Disease | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) years | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| Diabetes Mellitus - Mesenteric Thrombosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 3-23-69 | | Mesenteric Thrombosis | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1966 , to 24 March, 1969 , that (I) (we) last saw the deceased alive on 24 March 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| DeWitt E. DeLauter MD | | 3-24-69 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| DeWitt E. DeLauter | | 3848 Porter St NW Wash D.C. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Removal | | 3-26-1969 | | | | Granville, Ohio | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Joseph Gawler's Sons, Inc., 40250 Wisc. Ave. N.W., Wash., D.C., 20016 | | MAR 26 1969 | | Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|---|--|-------------------|--|--|------------------------|-----------------------------------|--|--|
| 04147 | | CERTIFICATE OF DEATH | | | | | | 04139 | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| HELENE Spangler M | | | LANCASTER | | | 3 Month 31 Day 69 Year | | | 12 A M | | |
| 3 SEX | | 4. RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 UNDER 1 YEAR | | 7E UNDER 24 HRS. | |
| FEMALE | | WHITE | | 4/9/96 | | 72 YRS. | | MONTHS DAYS HOURS M.N. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | |
| TENN. | | USA | | | | MONTGOMERY | | | Ma | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| SILVER SPRING | | | HOLY CROSS HOSP. | | | housewife | | | own home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| VA | | | Hanover | | Mechanicsville | | <input type="checkbox"/> YES <input type="checkbox"/> NO | | Eastern View Rt.#1 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| UNK | | | SPENGLER | | | UNK | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | Address | | | | |
| NO | | | 229-68-0662 | | HENRI E DIDOT | | -8417 MILFORD AVE, S.S. MD | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | | WKS | |
| 1830 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | WKS. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | WKS. | |
| (b) carcinomatosis | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) carcinoma of ovary | | | | | | | | | | WKS. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| CORONARY ARTERY DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/12, 1969, to 3/30, 1969, that (I) (we) last saw the deceased alive on 3/30, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | |
| Albert H. Grollman MD | | 3/31/69 | | ALBERT H. GROLLMAN | | 1106 SPRING ST. SILVER SPRING | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | April 1, 1969 | | Woodland Cemetery | | Ashland, Virginia | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Warner E. Pumphrey, Inc. | | DATE APR 7 1969 | | Charles Judge | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Belknap Heights Medical Examiner

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|------------------------------|--|--|--|---|--|------------------------|--|-----------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Irene | | | B Lanchester | | | 3 Month 28 Day 69 Year | | | 1239 | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. DAYS | |
| female | | w. cac. | | 11/3/1897 | | 71 YRS | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Colorado | | US | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | | | Holy Cross Hospital | | | housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Md | | | Montg. | | | Silver Spr. | | | 10805 Huntley Place | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| Max NMI Briegleb | | | Mary I Thoroloway | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT Address | | | | | |
| no | | | 217-48-3596 | | | Horace P./10805 Huntley Pl. SS. Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Essential Hypertension</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Atherosclerosis</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral Thrombosis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/10/53</u> , to <u>3/28/69</u> , that (I) (we) lost saw the deceased alive on <u>3/22/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | |
| | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Cremation | | | 3/29/1969 | | | Lee's Crematory | | | 300 4th St. N.E. Wash. D.C. | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | | |
| Lee Funeral Home, 300 4th St. NE, Wash, D.C. | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR DATE | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| APR 2 1969 | | | | | | <i>[Signature]</i> | | | | | |

VI 100.10

VI 100.10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15
45M - 1/1/69

| | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|--|--|
| 04149 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04141 | | | | | |
| 1. DECEASED NAME
(Type or print) <i>Benjamin H. LARman.</i> | | | | | | 2a. DATE OF DEATH
Month <i>3</i> - Day <i>30</i> - Year <i>69</i> | | 2b. HOUR
<i>4:28 PM</i> | | | |
| 3 SEX
<i>MALE</i> | | 4 RACE
<i>White</i> | | 5 DATE OF BIRTH
<i>4-25-07</i> | | 6 AGE (in years
last birthday)
<i>61</i> YRS. | | 7 UNDER 1 YEAR
MONTHS
DAYS | | 8 UNDER 24 HRS
HOURS
MIN | |
| 7a BIRTHPLACE (State or foreign
country)
<i>Id.</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
<i>Montgomery.</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda.</i> | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital,
give street address)
<i>Suburban.</i> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired).
<i>Landscaping</i> | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution
admission) STATE
<i>Id.</i> | | | | 13b COUNTY
<i>Montgomery</i> | | 13c CITY OR TOWN
<i>Bojds</i> | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER
<i>Box #218</i> | |
| 14 FATHER'S NAME - First
<i>George</i> | | | | Middle
<i>LARman</i> | | 15 MOTHER'S MAIDEN NAME First
<i>Bessie.</i> | | | | Middle
<i>Monard.</i> | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>No</i> | | | | 16b SOCIAL SECURITY NO
<i>218-07-2384</i> | | 17 INFORMANT
<i>Alice Hawse - Bojds Md</i> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last (b) <i>Bronchogenic Carcinoma</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>2 months</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION
<i>3/25/69</i> | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Bronchial obstruction</i> | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | 21f LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/20</i> , 19 <i>69</i> , to <i>3/26</i> , 19 <i>69</i> , that (I) (we) last
saw the deceased alive on <i>3/26</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Dr. A. J. ...</i> | | | | | | 22c. DATE SIGNED
<i>3/27/69</i> | | 22d. PHYSICIAN'S
NAME (Type) | | | |
| 23a BURIAL, CREMATION,
REMOVAL (Specify) | | 23b DATE
<i>3/29/69</i> | | 23c NAME OF CEMETERY OR CREMATORY
<i>Monocacy</i> | | 23d LOCATION (City or Town)
<i>Beallsville Monty. Md</i> | | (County) | | (State) | |
| 24 FUNERAL DIRECTOR
<i>William B. Helton, Beaneville, Md</i> | | | | | | 25a REC'D BY REG. STRAR
<i>APR 2 1969</i> | | 25b REGISTRAR'S SIGNATURE
<i>W. Charles ...</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please leave carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) <i>William Tennette Leaman</i> | | | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| | | | | | | Month <i>3</i> Day <i>31</i> Year <i>69</i> | | 5 <i>03</i> PM | |
| 3 SEX <i>Female</i> | | 4. RACE <i>Caucasian</i> | | 5 DATE OF BIRTH <i>June 12, 1899</i> | | 6 AGE (In years last birthday) <i>69</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | | | |
| 10 CITY OR TOWN OF DEATH <i>Rockville</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Foranac Valley Day Home</i> | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even "retired") <i>Housewife</i> | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE <i>Maryland</i> | | 13b COUNTY <i>Montg</i> | | 13c CITY OR TOWN <i>Clarksburg</i> | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last <i>William Henson Leaman</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Susie J. Mullard</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service) | | | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT <i>Miss Rebecca Leaman</i> Address <i>Bermentown Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> | | | | | | | | <i>1 hr</i> | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Ca.</i> | | | | | | | | <i>6 mos</i> | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ca. of Pancreas</i> | | | | | | | | <i>1 yr</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetic Mellitus</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1/10</i> , 19 <i>55</i> , to <i>3/21</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>3/21</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Stephen H. Jones M.D.</i> | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>3/21/69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>W. B. Thilton</i> | | | | 22e. ADDRESS <i>Barnesville Md.</i> | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>3/25/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Methodist</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Clarksburg Montg. Md.</i> | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| <i>W. B. Thilton</i> | | <i>MAR 28 1969</i> | | <i>Charles Judge</i> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|--|--|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21200 | | | | | | | | | |
| 04151 | | | | | | | | | |
| Item 23 Film 410 3/14/69 kk | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| NAOMI ELIZABETH LEE | | | | | | MARCH | | 5 Day 1 Year 9:30 AM | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER YEAR | |
| FEMALE | | NEGRO | | 12 MARCH 1931 | | 37 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| VIRGINIA | | USA | | | | MONTGOMERY | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BETHESDA | | | NAVAL HOSPITAL, BETHESDA | | | RECORD ANALYST | | NAVY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| VIRGINIA | | | ARLINGTON | | ARLINGTON | | 121 S. ROLFE ST. | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| BERNARD MORTON | | | HATTIE E. LOCKETT | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | |
| NO | | | 572 36 3524 | | WILLIAM M. LEE 121 S. ROLFE ST. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma breast with metastases | | | | | | | | | |
| 174X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 10 FEB. 1969, to 5 MARCH 1969, that (X) (we) last saw the deceased alive on 5 MARCH 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED |
| Michael D. GORMAN, M. D. | | | | | | | | | MARCH 1969 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3-10-69 | | ARLINGTON NATIONAL CEMETERY | | ARLINGTON, ARLINGTON, VA. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| CHIN FUNERAL HOME CLEBE RD., ARLINGTON, VA. | | | | | DATE MAR 10 1969 | | Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

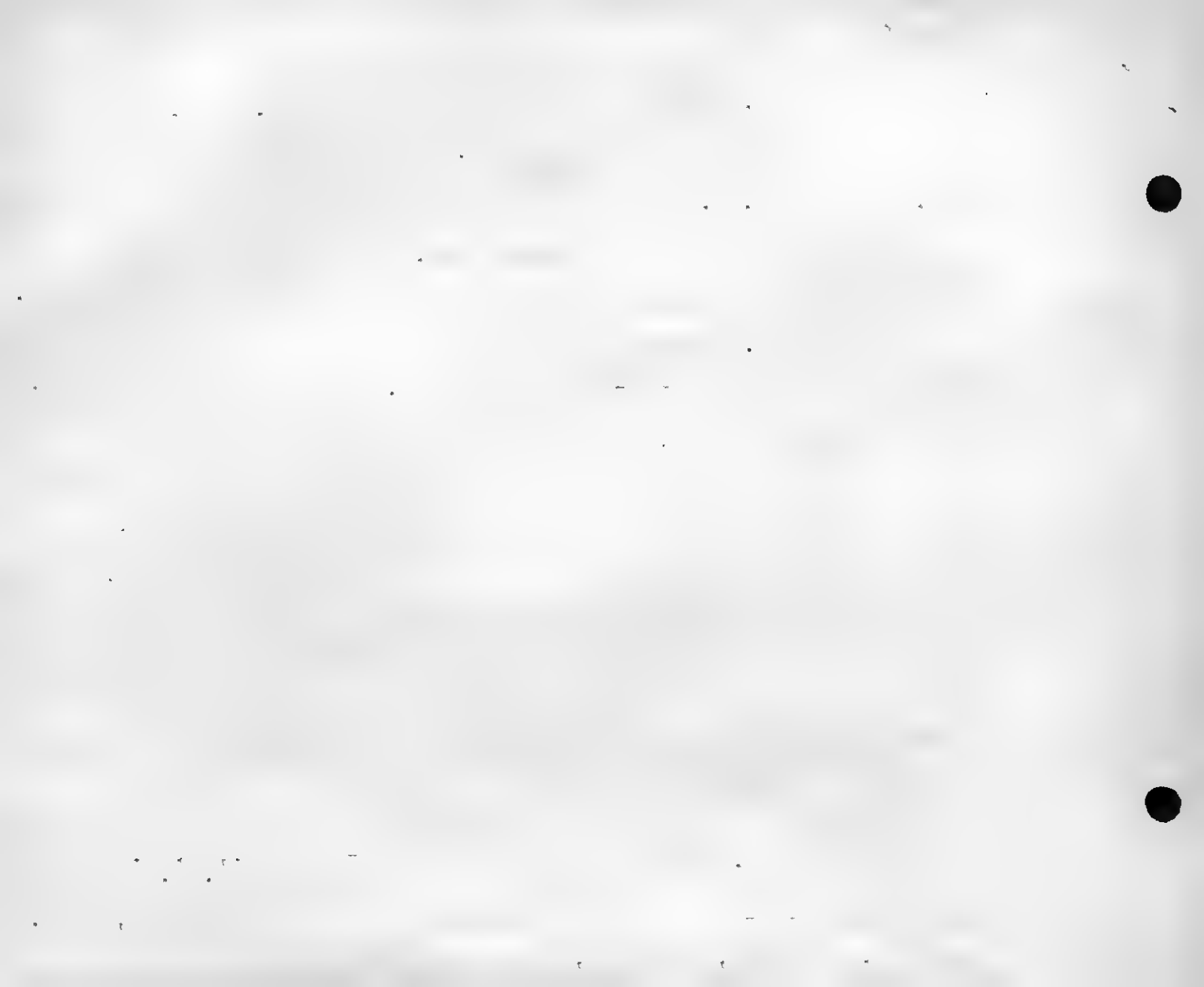
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|---------|---|---|---|---------------------------------|---|--|
| 04152 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04144 | |
| 1. DECEASED NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | |
| BERNARD E LESTER | | | | | | MARCH 31 1969 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | 7. IF UNDER 1 YEAR
MONTHS DAYS | |
| MALE | WHITE | 7/26/29 | | | 39 YRS. | IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| W. VA. | | U. S. A. | | | | MONTGOMERY | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BETHESDA | | SUBURBAN | | LETTER CARRIER | | U.S. Post Office | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| MARYLAND | | MONTGOMERY | | GERMANTOWN | | MIDDLEBROOK TRAILER COURT | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | |
| VAN LESTER | | | ANGIE P. BRIGGS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| YES 1951-55 | | | | IVORY LESTER - WIFE - SAME | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adrenal Cortical Failure
1537 DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) Carcinoma of Bowel | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 15, 1969, to March 31, 1969, that (I) (we) lost the deceased alive on 3/31/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | |
| 22b. SIGNATURE Robert A. Barnett MD | | | | 22c. DATE SIGNED 3-31-69 | | 22d. PHYSICIAN'S NAME (Type) Robert A. Barnett | |
| 22e. ADDRESS 809 Viers Mill Road, Rockville, Md. | | | | | | | |
| 23a. BURIAL, CREMATION BY WHOM? | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial Trans | | 4/4/69 | | | | Sophia, West Virginia | |
| 24. FUNERAL DIRECTOR Tysons Wheeler Funeral Home 1331 Rock Pike, Rockville, Maryland | | | | 25a. REC'D BY REGISTRAR APR 7 1969 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please separate carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|--|---|--|--|---------------------------------|--|--|--|------------------------------|--|
| 04153 | | CERTIFICATE OF DEATH | | | | | | | | 04145 | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
M | | | |
| MARY R. LEWIS | | | | | | Mar. 14, 1969 | | | 5:20 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| Female | | White | | Aug. 25, 1883 | | | 85 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIAGE STATUS
<input checked="" type="checkbox"/> NEVER MARRIED
<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | | | 9. COUNTY OF DEATH | | | | | |
| Minn. | | U. S. | | | | | MONTGOMERY | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Chevy Chase | | | 4712 Chevy Chase Blvd. | | | Housewife | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY, J.M. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| Maryland | | | Montgomery | | | Chevy Chase | | | 4712 Chevy Chase Blvd. | | | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | | | |
| Albert E. Kaech | | | Ellen Ryan | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | | |
| No | | | 524-62-8272 | | | Sister
J1 Monica K. Payne | | | Same as Item 13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per PART I DEATH WAS CAUSED BY.) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION | | | | | | | | | | MINUTES | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (b) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | | YEARS | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) GENERALIZED ARTERIOSCLEROSIS | | | | | | | | | | YEARS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| CHRONIC RENAL INSUFFICIENCY WITH AZOTEMIA | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | |
| | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG 9, 1966, to MAR 14, 1969, that (I) (we) last saw the deceased alive on MARCH 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (do not) view the body after death | | | | | | | | | | | | |
| 22b. SIGNATURE
George A. Tralka M.D. | | | | | | ATTENDING PHYSICIAN
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
MARCH 15, 1969 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | | |
| GEORGE A. TRALKA | | | | | | 915-19th St., N. W.
Washington, D. C. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 3-18-69 | | Evergreen Cemetery | | | | Colorado Springs, Colo. | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. RECD BY REGISTRAR
DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | | | MAR 20 1969 | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

| 04154 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04146 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last
Magdalen Frances Liammari | | | | | | | | | | Month Day Year
March 25 1969 | | | | | | | | | | 7:50 AM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 SEX
Female | | | | | | | | | | 4 RACE
White | | | | | | | | | | 5 DATE OF BIRTH
5 January 1916 | | | | | | | | | | 6 AGE (In years last birthday)
55 YRS | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN | | | | | | | | | | | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country)
Minnesota | | | | | | | | | | 7b CITIZEN OF WHAT COUNTRY?
USA | | | | | | | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | | | | | | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center | | | | | | | | | | 12a USUAL OCCUPATION (Kind of work done during most of work no life, even if retired)
housewife | | | | | | | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
Virginia | | | | | | | | | | 13b COUNTY
Falls Church | | | | | | | | | | 13c CITY OR TOWN
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e STREET AND NUMBER
2926 Lockport Drive | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Joseph Zitzmann | | | | | | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Rose Ourada | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
Yes | | | | | | | | | | 16b SOCIAL SECURITY NO.
(If yes give year of dates of service)
1942-46 | | | | | | | | | | 17 INFORMANT
The Medical Records Address
The Clinical Center, NIH, Bethesda, Md. 20014 | | | | | | | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Asphyxia secondary to aspiration of vomitus</u>
<u>duui</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Lymphosarcoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 minutes
3 years | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | | | | | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>6 March</u> , 19 <u>69</u> , to <u>25 March</u> , 19 <u>69</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>25 March</u> , 19 <u>69</u> , and that in <u>(our)</u> (my) opinion death occurred on the date and hour and from the causes stated above, <u>(X)</u> (we) (did) (did not) view the body after death. | | | | | | | | | | 22b SIGNATURE
<u>Clarence H. Brown, M.D.</u>
DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c DATE SIGNED
25 March 1969 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Clarence H. Brown, M.D. | | | | | | | | | | 22e ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | | | | | | 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | | | | | 23b DATE
Mar. 28, 1969 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
National Memorial Park | | | | | | | | | | 23d LOCATION (City or Town) (County) (State)
Falls Church, Fairfax, Va. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Pearson's Funeral Home</u> | | | | | | | | | | ADDRESS
Falls Church Va | | | | | | | | | | 25a REC'D BY REGISTRAR
MAR 27 1969 | | | | | | | | | | 25b REGISTRAR'S SIGNATURE
<u>Clarence H. Brown</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION



notified Dr. Reap

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1

04155

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04147

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|---|--|
| 1 DECEASED NAME
(Type or print)
First Middle Last
<i>Helton G Littleford</i> | | | 2a. DATE OF DEATH
Month Day Year
<i>3 4 69</i> | | | 2b. HOUR
<i>2:30 P M</i> | | | | | |
| 3 SEX
<i>Female</i> | | 4 RACE
<i>White</i> | | 5 DATE OF BIRTH
<i>February 27, 1897</i> | | 6 AGE (In years last birthday)
YRS. MONTHS DAYS
<i>71 0 2</i> | | IF UNDER 1 YEAR
MONTHS DAYS
<i>0 2</i> | | IF UNDER 24 HRS.
HOURS MIN
<i>0 0</i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
<i>Montgomery</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Kensington</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>2609 McComas Avenue</i> | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)
<i>Housewife - own home</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUA. RESIDENCE (Where deceased lived, if inst. tut on: Residence before admission) STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Kensington</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>2609 McComas Avenue</i> | | | |
| 14 FATHER'S NAME
First Middle Last
<i>Richard Windsor</i> | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Rose Hutchins</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>215-34-3116</i> | | 17 INFORMANT
<i>Mr. Robert R. Bladen Kensington, Maryland</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Adenocarcinoma of stomach</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>5 months</i> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>Jan. 23, 1969</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Carcinoma of stomach</i> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or RFD No City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 4, 1935</i> to <i>March 4, 1969</i> , that (I) (we) last saw the deceased alive on <i>July 21, 1969</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Katharine R. Chapman, M.D.</i> | | | | DEGREE
<i>M.D.</i> | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>March 5, 1969</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Katharine Chapman</i> | | | | 22e. ADDRESS
<i>3931 Baltimore Ave. Kensington, Md.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>March 10, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parlman Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Rockville Montgomery Md.</i> | | | | | |
| 23e. FUNERAL DIRECTOR
<i>Wm. E. Murphy, Inc.</i> | | | | ADDRESS
<i>8434 Georgia Avenue Silver Spring, Md.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 10 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

783-2258

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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16
2

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 04156 | | | 04148 | | | | | | |
| 1. DECEASED NAME (Type or print) MARY AGNES | | | First Middle Last LIVERETT | | | 2a. DATE OF DEATH Month Day Year MARCH 22 1969 | | | 2b. HOUR 6 00 |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH June 16 1906 | | 6. AGE (In years last birthday) 62 YRS | | 7. JUNIOR YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH MONTGOMERY | | | |
| 10. CITY OR TOWN OF DEATH Bethesda | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY at home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md | | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Bethesda | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 309 Audrey Lane |
| 14. FATHER'S NAME First Middle Last Unknown Thompson | | | 15. MOTHER'S MAIDEN NAME First Middle Last Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO 5-78-22-9416 | | 17. INFORMANT George R. Liverett Address Same as #13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Bronchopneumonia | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) due to recurrent squamous cell carcinoma, cervix | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) 2 1/2 years. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1966 to 3/22/69 , that (I) (we) lost 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE Fredrick Y. Doniv | | | 22c. PHYSICIAN'S NAME (Type) FREDERICK Y. DONIV | | | 22d. ADDRESS 800-4th St. S.W. D.C. | | 22e. DATE SIGNED 3/22/69 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 3-25-69 | | 23c. NAME OF CEMETERY OR CREMATORY Washington National | | 23d. LOCATION (City or Town) (County) (State) Smithland Maryland | | |
| 24. FUNERAL DIRECTOR W. W. Chambers | | | 24b. ADDRESS 577-11th St. S.E. | | | 25a. REC'D BY REGISTRAR MAR 26 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|---|--|-----------------|---|--------------------------------|--|--|
| 04157 | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 04149 | | | | | | | | | |
| 1 DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a DATE KNOWN
OF EST. DEATH | | | 2b HOUR |
| William | | | D Lucas | | | Month Day Year | | | M |
| 3 SEX | | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 MONTHS |
| Male | | | White | | 2/21/22 | | 47 YRS | | 72 M |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED | | | 9 COUNTY OF DEATH |
| Kansas | | | USA | | | NEVER MARRIED | | | Montgomery |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY |
| Bethesda | | | Suburban Hosp | | | Retired | | | Real Estate |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? |
| MD | | | Mont | | | Chesley | | | YES NO |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO |
| Cecil J. Lucas | | | Nell | | | YES NO | | | 54-07-2236 |
| 17 INFORMANT | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? |
| Wife Mrs. W. D. Lucas | | | Subdural hematoma, right cerebral hemisphere | | | 20 AUTOPSY? | | | YES NO |
| 21a INJURY OCCURRED | | | 21b TIME OF INJURY Month, Day, Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) | | | 21d LOCATION Street or R.F.D. No |
| WHILE AT WORK | | | 9 P.M. 9 19 | | | P. | | | City or Town County State |
| 22a I certify that I took charge of the remains described above, held on death resulted from. | | | 22b DATE SIGNED | | | 22c NAME OF CEMETERY OR CREMATORY | | | 22d LOCATION (City or Town) (County) (State) |
| Natural causes | | | March 26, 1969 | | | Gate of Heaven Cem. | | | Silver Spring, Maryland |
| Accident | | | 22e REGISTRAR'S SIGNATURE | | | 22f REC'D BY REGISTRAR | | | 22g REGISTRAR'S SIGNATURE |
| Suicide | | | Robert A. Humphrey | | | APR 1 1969 | | | 7552 Wisconsin |
| Homicide | | | 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY |
| Undetermined manner | | | Burial | | | 3-29-69 | | | Gate of Heaven Cem. |
| 23d EXAMINER'S NAME (Type) | | | 23e DATE | | | 23f NAME OF CEMETERY OR CREMATORY | | | 23g LOCATION (City or Town) (County) (State) |
| JOHN G. BALL | | | 3-29-69 | | | Gate of Heaven Cem. | | | Silver Spring, Maryland |
| 23h EXAMINER'S NAME (Type) | | | 23i DATE | | | 23j NAME OF CEMETERY OR CREMATORY | | | 23k LOCATION (City or Town) (County) (State) |
| Robert A. Humphrey | | | 3-29-69 | | | Gate of Heaven Cem. | | | Silver Spring, Maryland |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04158

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04150

| | | | | | | | | | | | | |
|---|--|-------------------------------------|---|---|--|---|--|---|--|---|---|--|
| 1. DECEASED NAME
(Type or print)
Byron L Lutz | | | 2a. DATE OF DEATH
Month 5 Day 13 Year 69 | | | 2b. HOUR
10:11 P.M. | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Aug 19 1890 | | 6. AGE (In years lost birthday)
78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Pa | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md | | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Randolph Hills Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Auditor | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Government | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Md | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Chevy Chase | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3914 Aspen Street | | |
| 14. FATHER'S NAME
First Middle Last
John Monroe Lutz | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Alma Welch | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, No, or Unknown
Yes | | | 16b. SOCIAL SECURITY NO
214-34-6881 | | | 17. INFORMANT
Arlene Plotz | | | Address
3914 Aspen St Chevy Chase, Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Renal failure</u>
405X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Nephrosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Arteriosclerosis, genl.</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>9 Wks</u>
<u>5 yrs, 6 mos</u>
<u>15 yrs</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Cerebral vascular accident</u> <u>arterial embolism, rt lower leg</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 1969 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July, 1968</u> , to <u>Mar 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>Mar 12, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Philip H. Varmer, M.D.</u> | | | | | | DEGREE
M.D. | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
3-13-69 | |
| 22d. PHYSICIAN'S NAME (Type)
Philip H Varmer Md | | | | | | 22e. ADDRESS
10620 Georgia Ave Wheaton, Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, (Specify)
Burial | | | 23b. DATE
3-17-69 | | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Rockville Mont. Md | | | |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey | | | | | | ADDRESS
2557 Wisconsin Ave Bethesda, Md | | | 25b. REG'D BY REGISTRAR
MAR 19 1969 | | 25c. REGISTRAR'S SIGNATURE
<u>Charles J. Jones</u> | |

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
TOM REV 1 68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 04159 | | 04151 | |
| 1 DECEASED NAME (Type or Print) | | | |
| First Horace | | Middle Thomas | |
| Last MACEY Jr. | | 2a DATE KNOWN OF DEATH | |
| 3 SEX Male | | 4 RACE Cauc | |
| 5 DATE OF BIRTH July 31, 1916 | | 6 AGE (in years last birthday) 52 YRS | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b CITIZEN OF WHAT COUNTRY? USA | |
| 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Montgomery | |
| 10 CITY OR TOWN OF DEATH Bethesda | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Naval Hospital | |
| 12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. Navy | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived if institution admission) STATE Maryland | | 13b COUNTY Anne Arundel | |
| 13c CITY OR TOWN Pasadena | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e STREET AND NUMBER Rural Route 14, Box 20 | | 14 FATHER'S NAME | |
| First Horace | | Middle Thomas | |
| Last MACEY Sr. | | 15 MOTHER'S MAIDEN NAME | |
| First Harriet | | Middle D. | |
| Last Howard | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | |
| 16b SOCIAL SECURITY NO 1936-55 | | 17 INFORMANT Baltimore, Md. ADDRESS Horace T. Macey, III, 3230 Rolling Rd. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Confluent Broncho-Pneumonia</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia - Postoperative Repair of Abdominal Wounds 19 days -</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gun Shot Wounds of Abdomen -</u> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a DATE OF OPERATION 3/7/69 - | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Repair of Abdominal Wounds | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21a TIME OF INJURY Month, Day, Year 6:15 P.M. 7 Mar 19 69 | |
| 21b HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot in abdomen with 12 gauge shotgun | | 22a AUTOPSY? <input checked="" type="checkbox"/> INSPECTION? <input checked="" type="checkbox"/> INQUIRY? <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| 21c PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home | | 21f LOCATION Street or RFD No City or Town County Md. State Route 14, Box 20 Pasadena, Anne Arundel | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22b DATE SIGNED 27 March 1969 | |
| ACTUAL SIGNATURE John G. Ball | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) John G. Ball, M. D. | | ADDRESS (Street, city, town, or county) | |
| 23a BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b DATE 4-1-69 | |
| 23c NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | 23d LOCATION (City or Town) (County) (State) Baltimore Maryland | |
| 24 FUNERAL DIRECTOR Barranco Funeral Parlor | | 25a REC'D BY REGISTRAR APR 2 1969 | |
| Severna Park, Maryland | | 25b REGISTRAR'S SIGNATURE | |

FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit document. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04152 | |
|---|------------------|--------------------------------|---|---|--|--|--|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) FRED | | | First Middle Last MAGNUS | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST <input type="checkbox"/> MATED <input type="checkbox"/> 3-16-69 | | | 2b. HOUR 4:20 | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH 8-4-18 | 6. AGE (In years last birthday) 50 YRS | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD 3-16-69 | | | 2d. HOUR 4:20 | | |
| 7a. BIRTHPLACE (State or foreign country) N.D. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH MONTGOMERY | | |
| 10. CITY OR TOWN OF DEATH TAKOMA PARK, | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) WASH SAN AND HOSP | | | 12a. USJA. OCCUPATION (Kind of work done during lifetime or last paid employment) None | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD | | | 13b. COUNTY MONT. | | | 13c. CITY OR TOWN TAKOMA PARK YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 7403 MAPLE AVE | | |
| 14. FATHER'S NAME FRED First Middle Last MAGNUS | | | 15. MOTHER'S MAIDEN NAME ANNETTA First Middle Last HARMON | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT HOSP RECORD | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive acute intracerebral hemorrhage | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) associated with Hemophilia | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Belden R. Neap | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 3/16/1969 | | |
| EXAMINER'S NAME (Type) BELDEN R. NEAP M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS 254 Carroll Dr N.W.T. | | | | | |
| 23a. BIRTH, CREMATION, REMOVAL (Specify) CREMATION | | | 23b. DATE March 17, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY For Lincoln Crematory | | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pa. Dist. Md. | | |
| 24. FUNERAL DIRECTOR J.A. Walters | | | ADDRESS 254 Carroll Dr N.W.T. | | | 25a. REC'D BY REG STRAR MAR 19 1969 | | | 25b. REG STRAR'S SIGNATURE J.A. Walters | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|---|---|---|--|-----------------------|----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Francis E. Maloney | | | | | | Month Day Year
May 14 1969 | | | 11:45 PM |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 IF UNDER 1 YEAR | |
| Male | | White | | 3/9/97 | | 72 YRS | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Nebraska | | USA | | | | Montgomery | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY |
| Bethesda | | | Suburban Hospital | | | Real Estate | | | DEARF T. Bate |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before address) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER |
| Maryland | | | Montgomery | | Chevy Chase | | | | 6915 Ridgewood Ave |
| 14 FATHER'S NAME First Middle Last | | | 15 MOTHER'S M A DEN NAME First Middle Last | | | | | | |
| Patrick Paul Maloney | | | Mary Torpy | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give way or dates of service) | | | 16b SOC. A. SECURITY NO. | | 17 INFORMANT Address | | | | |
| YES WWI | | | | | Elizabeth Maloney - wife - old same. | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction | | | | | | | | | |
| 4104 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) Coronary Artery Disease | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or RFD No City or Town County State | | | | | |
| 22a I certify that (I) (the hospital) attended the deceased from Jan 1964 to May 14, 1969, that (I) (we) saw the deceased alive on May 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b SIGNATURE James J. Foster M.D. DEGREE | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED 3/14/69 | | |
| 22d PHYSICIAN'S NAME (Type) James J. Foster | | | | | 22e ADDRESS 915- 1946 N.W. Washington, DC | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3-18-69 | | Gate of Heaven Cem. | | Silver Spring, Maryland | | | |
| 24 FUNERAL DIRECTOR ADDRESS | | | | | 25a REC'D BY REGISTRAR DATE | | 25b REGISTRAR'S SIGNATURE | | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | MAR 20 1969 | | | | |

04162

CERTIFICATE OF DEATH

04154

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME
(Type or print) BERTHA | | First E Middle MANN Last | | 2a DATE OF DEATH
March Month 6 Day 1969 | | 2b HOUR
2 P. M. | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
April 12, 1880 | | 6 AGE (In years
last birthday) 88 YRS | |
| 7a BIRTHPLACE (State or foreign
country) Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | |
| 10 CITY OR TOWN OF DEATH
Rockville | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Potomac Valley Nurs. Home | | 12a USUAL OCCUPATION (Kind of work done
during most of last year or if retired) Housewife | | 12b KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before
admission) Maryland STATE | | 13b. COUNTY
Montgomery | | 13c CITY OR TOWN
Rockville | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e STREET AND NUMBER
100 Dale Drive, Rockville | | 13f STATE
Maryland | | 14 FATHER'S NAME First Charles W. Creek Middle Last | | 15 MOTHER'S MAIDEN NAME First Sarah Mallott Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO
----- | | 17 INFORMANT
Boyd H. Mann - son - same item # 13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cholerae Pneumoniae
456X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL,
BETWEEN ONSET AND DEATH
12 hrs | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Long Term Congestive Heart Failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from out 1950 to 6 March 1969 , that (I) (we) lost
saw the deceased alive on 6 March 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
W. S. Murphy | | DEGREE
MD | | ATTENDING
PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
6 March 69 | |
| 22d. PHYSICIAN'S
NAME (Type) William S. Murphy | | 22e. ADDRESS
615 W. Montgomery Ave., Rockville, Md. | | | | | |
| 23a BURIAL, CREMATION,
REMOVAL (Specify) Burial | | 23b DATE
3/8/69 | | 23c NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Pk | | 23d LOCAT ON (City or Town) (County) (State)
Rockville, Montgomery, Md. | |
| 24 FUNERAL DIRECTOR
Tyson Wheeler Funeral Home 1331 Rock. Pike | | ADDRESS
Rockville, Maryland | | 25a. REC'D BY REGISTRAR
DATE April 10 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

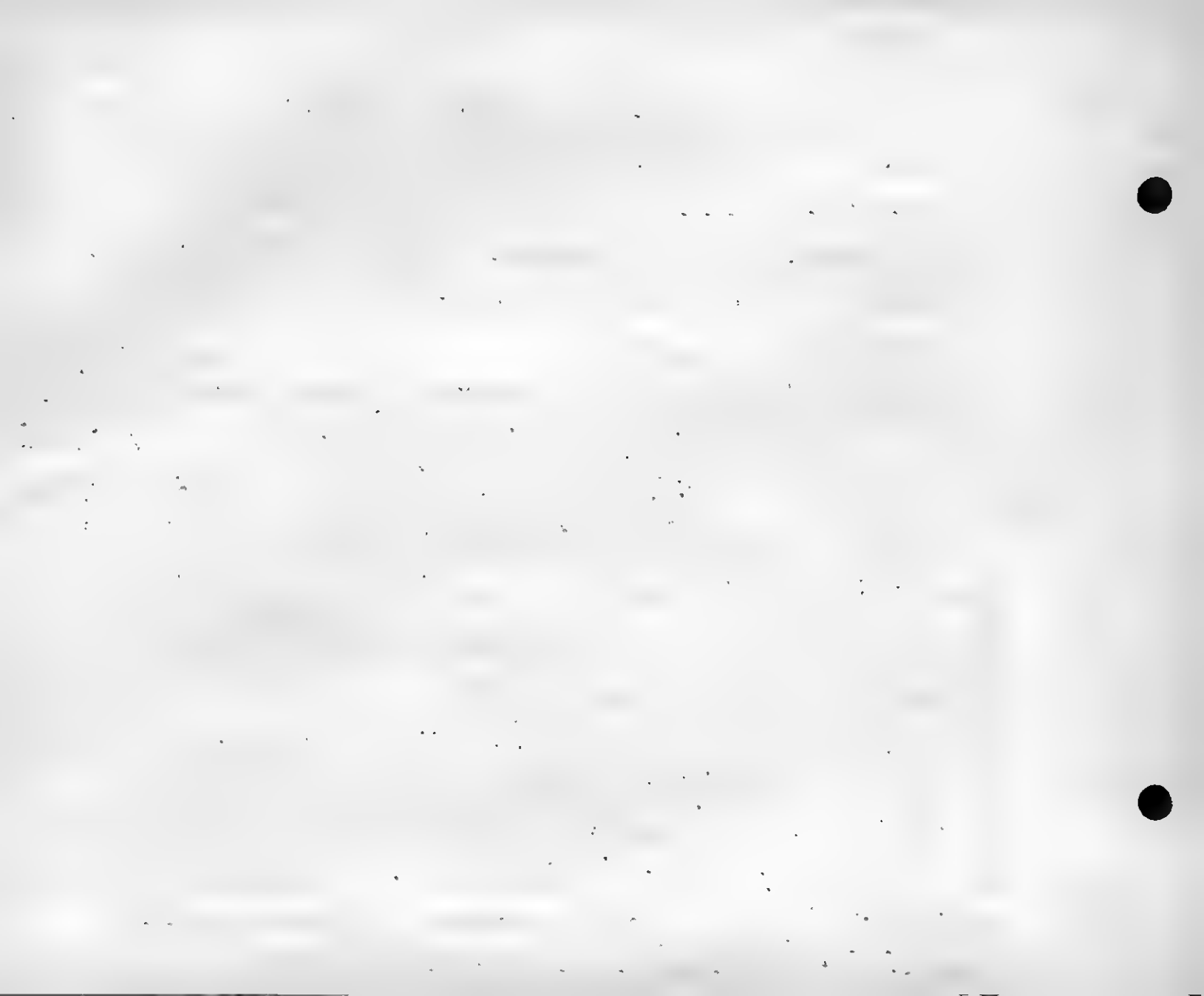
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|---|--|---|---|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 04163 CERTIFICATE OF DEATH 04155 | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <u>James A Matthews</u> | | | | | 2a. DATE OF DEATH <u>3</u> Month <u>30</u> Day <u>69</u> Year | | | 2b. HOUR <u>1:58</u> M | | |
| 3. SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH <u>10/3/1889</u> | | 6. AGE (In years last birthday) <u>79</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) <u>Penna.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Montgomery</u> Md | | | | |
| 10. CITY OR TOWN OF DEATH <u>Wheaton</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Randolph Hills Nursing Home</u> | | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <u>Rest. Owner</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Md.</u> | | | 13b. COUNTY <u>Montgomery</u> | | 13c. CITY OR TOWN <u>Bethesda</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>6614 Braeburn Parkway</u> | |
| 14. FATHER'S NAME First <u>Levi</u> Middle <u>Matthew</u> Last <u>5</u> | | | 15. MOTHER'S MAIDEN NAME First <u>Whelmy</u> Middle <u>Tinklepaugh</u> Last <u>Anna</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. <u>579017332</u> | | 17. INFORMANT <u>WIFE</u> Address <u>6614-BRAEBURN PKWY</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary and Cerebral Embolism</u> | | | | | | | | | <u>27 hours</u> | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL Arteriosclerosis</u> | | | | | | | | | <u>1st year</u> | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u> | | | | | | | | | <u>1st year</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>May 29, 1967</u> to <u>Mar 30, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 30, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | |
| 22b. SIGNATURE <u>R. Stephen Hulburt, MD, DEGREE</u> | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>March 20, 1969</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>R. STEPHEN HULBURT, MD</u> | | | | | 22e. ADDRESS <u>3000 Dent Place, N.W.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| <u>BURIAL</u> | | <u>APR. 2, 1969</u> | | <u>GATE OF HEAVEN CEM.</u> | | <u>WHEATON MD.</u> | | | | |
| 24. FUNERAL DIRECTOR <u>John F. H. (DEVELOPMENTAL HEALTH)</u> | | | | | 25a. REC'D BY REGISTRAR <u>WASH. D.C.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |
| | | | | | DATE <u>APR 7 1969</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) <u>Lewis</u> | | | First <u>J.</u> Middle <u>Matthews</u> Last | | | 2a. DATE OF DEATH
Month <u>MARCH</u> Day <u>20</u> Year <u>1967</u> | | 2b. HOUR
<u>6:45</u> M | | | |
| 3 SEX
<u>Male</u> | | 4 RACE
<u>Caucasian</u> | | 5 DATE OF BIRTH
<u>May 12, 1895</u> | | 6 AGE (in years last birthday)
<u>73</u> YRS. | | 7 IF UNDER YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a BIRTHPLACE (State or foreign country)
<u>Wash., D. C.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Montgomery</u> Md | | | | | |
| 10 CITY OR TOWN OF DEATH
<u>Silver Spring</u> | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>1905 Elkhart St.</u> | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<u>Retired - Johns Hopkins Lab.</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE
<u>Maryland</u> | | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Silver Spring</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
<u>1905 Elkhart St.</u> | | |
| 14 FATHER'S NAME First <u>Lewis</u> Middle <u>J.</u> Last <u>Matthews</u> | | | 15. MOTHER'S MAIDEN NAME First <u>Annie</u> Middle <u>Williams</u> Last | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <u>Yes</u> (If yes give war or dates of service) <u>WW I</u> | | | | | |
| 16b. SOCIAL SECURITY NO.
<u>yes</u> | | | 17 INFORMANT
<u>Elizabeth E. Matthews</u> | | | 18 ADDRESS
<u>1905 Elkhart St. Silver Spring, Md.</u> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCT</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
<u>Cerebral Arterio Sclerotic Vascular Disease</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1967</u> to <u>MARCH 19 1967</u> , that (I) (we) last saw the deceased alive on <u>MARCH 19 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (do not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>George B. Patrick, M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED
<u>3-20-67</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>George B. Patrick, M.D.</u> | | | | | | | | | | 22e. ADDRESS
<u>9225 Oldhouse Rd Silver Spring, Md.</u> | |
| 23b. DATE
<u>3-24-67</u> | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rock Creek cemetery</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Washington, D.C.</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | |
| 24 FUNERAL DIRECTOR
<u>E. S. Smith</u> | | | 25a. REC'D BY REGISTRAR
<u>Waner E. Pumphrey, Inc. 8434 Ga. ave. Silver sp</u> | | | 25b. REGISTRAR'S SIGNATURE
<u>DATE MAR 28 1967</u> | | 25c. DATE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04165

04157

| | | | | | | | | | |
|--|--------|---|-----------------|---|---|--|---|---------------------------|--|
| 1 DECEASED NAME
(Type or print) | | First | Middle | Last | 2c DATE OF DEATH | | | 2b. HOUR | |
| Alivia | | | | Maxson | Month | Day | Year | 3:15 PM | |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (in years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS |
| Female | white | | 10-20-77 | | 91 YRS | | MONTHS | DAYS | HOURS MIN |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| West Virginia | | America | | | | Montgomery Md | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Takoma Park | | Washington Sanitarium & Hospital | | None | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d AS DE CITY LIMITS? | | 13e STREET AND NUMBER | |
| Washington D.C. | | Montgomery | | Washington D.C. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 7437 Keystone Lane | |
| 14. FATHER'S NAME | | First | Middle | Last | 15 MOTHER'S MAIDEN NAME | | First | Middle | Last |
| Albert | | | | Vee | Melissa | | | | Clark |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | | | | |
| None | | 176-30-9457 | | Records - Washington Sanitarium & Hospital | | | | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>485V</u> <u>Branchial Pneumonia</u> | | | | | | | | | <u>Two Days</u> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| (b) <u>Generalized Debilitation with Acute Peritonitis</u> | | | | | | | | | <u>Two Weeks</u> |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| <u>Congestive Heart Failure, Arteriosclerosis Generalized</u> | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC) | | 21f LOCATION | | Street or R.F.D. No | | City or Town | County State |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January, 1968</u> , to <u>March 21, 1969</u> , that (I) (we) last saw the deceased alive on <u>March 21</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED | |
| <u>Stuart L Nelson MD</u> | | | | | | | | <u>3-21-69</u> | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e ADDRESS | | | | | |
| Stuart L Nelson MD | | | | 831 University Blvd Silver Spring | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | (State) |
| Burial | | 3-24-69 | | Mt. Olive Baptist | | Doddridge Cty, W. Va | | | |
| 24 FUNERAL DIRECTOR | | | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| Robert A Pumphrey | | | | 7557 Wisconsin Ave Bethesda, Md | | MAR 26 1969 | | <u>William J. George</u> | |



CERTIFICATE OF DEATH

04158

04168

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(Type or print) ROBERT L. MAY | | | 2a. DATE OF DEATH
Month 3 Day 2 Year 69 | | | 2b. HOUR
4:20 M | |
| 3 SEX
MALE | | 4 RACE
CAUCASIAN | | 5. DATE OF BIRTH
10/31/22 | | 6. AGE (In years last birthday)
46 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Attorney | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY MONTGOMERY | | 13c. CITY OR TOWN ROCKVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
13527 VANDALIA DRIVE | | 14 FATHER'S NAME
First ROBERT Middle L. Last MAY | | 15. MOTHER'S MAIDEN NAME
First ELIZABETH Middle L Last WEAVER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES | | 16b. SOCIAL SECURITY NO.
237-26-4262 | | 17 INFORMANT
MARY H. MAY, WIFE, SPONE #13 | | Address | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF WITH LEFT VENTRICULAR RUPTURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost CORONARY THROMBOSIS-OCCLUSION
DUE TO, OR AS A CONSEQUENCE OF CIRCUMFLEX BRANCH, LEFT CORONARY
(c) ARTERIOSCLEROTIC CORONARY A. DISEASE | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
CIRCA 15-18 Hours
-INDEFINITE |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
PULMONARY EDEMA | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/1, 1969 , to 3/2, 1969 , that (I) (we) lost the deceased alive on 3/2, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Lawrence D. Marcus, M.D. | | | | 22c. DATE SIGNED
3/2/69 | | 22d. PHYSICIAN'S NAME (Type) Lawrence D. Marcus | |
| 22e. ADDRESS
1111 Spring Street, Silver Spring, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-5-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Culpeper National Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Prince William Co. Va. | |
| 24. FUNERAL DIRECTOR
Lawson's Sons, Inc., N.W. Wash., D.C. 20016 | | | | 25a. REC'D BY REGISTRAR
DATE MAR 10 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04167

CERTIFICATE OF DEATH

04159

| | | | | | | |
|--|--|--|--|--|--|---|
| 1 DECEASED-NAME (Type or print) First Middle Last
MABEL M. MAYER | | | 2a. DATE OF DEATH (Month Day Year)
May 30 1969 | | 2b. HOUR
3:30 P M | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
April 5, 1878 | | 6. AGE (In years last birthday) YRS.
90 |
| 7a. BIRTHPLACE (State or foreign country)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md |
| 1d. CITY OR TOWN OF DEATH
Silver Spring | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
8702 Sundale Dr. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b. K NO OF BUSINESS OR INDUSTRY |
| 13a. USJA RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER
8702 Sundale Drive |
| 14. FATHER'S NAME First Middle Last
Henry Hassel | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Reilly | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
no | | 16b. SOCIAL SECURITY NO.
578-48-5340 D | | 17 INFORMANT Address
Mrs. Helen Townsend Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) General Visceral Failure
DUE TO, OR AS-A CONSEQUENCE OF, (b) Generalized Arteriosclerosis
DUE TO, OR AS-A CONSEQUENCE OF (c) Semility
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Partial Intestinal Obstruction | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1960 to May 30, 1969 , that (I) (we) last saw the deceased alive on May 30 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Francis T. Sharpe M.D. | | | | 22c. DATE SIGNED
May 30, 1969 | | |
| 22d. PHYSICIAN'S NAME (Type)
Francis T. Sharpe | | | | 22e. ADDRESS
4105 Wisconsin Ave Wash DC | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
4-2-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | |
| 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Maryland | | 24. FUNERAL DIRECTOR
Francis J. Collins | | 25a. RECD BY REGISTRAR
APR 3 1969 | | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 500 University Blvd. W. Silver Spring, Md. | | | | |



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04168

CERTIFICATE OF DEATH

04160

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) <u>KATHRYN V. McCulloh</u> | | | 2a. DATE OF DEATH
Month <u>3</u> Day <u>29</u> Year <u>1969</u> 2b. HOUR <u>6:15 P.M.</u> | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH
<u>Apr 3, 1891</u> | |
| 7a. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
<u>Rockville</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>Potomac Valley Nursing Home, Investments</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<u>Investments</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution, Residence before admission) STATE <u>Alabama</u> | | 13b. COUNTY <u>Jefferson</u> | | 13c. CITY OR TOWN <u>Birmingham</u> | |
| 14. FATHER'S NAME First <u>George</u> Middle <u>W.</u> Last <u>McCulloh</u> | | 15. MOTHER'S MAIDEN NAME First <u>Linnie</u> Middle <u>Burkey</u> Last <u>bile</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO. <u>493 60-1763</u> | | 17. INFORMANT <u>U. L. Beale (nephew)</u> | | Address <u>222 Forest Ave</u> | |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE C.V.A.</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>4001</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>24 HR.</u>
<u>YEARS</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>P.S.H.T. & C.H.F.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAR 28, 1969</u> , to <u>MAR 29, 1969</u> , that (I) (we) last saw the deceased alive on <u>MAR 28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) (d d) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Robert C. Daddario MD</u> | | | | 22c. DATE SIGNED <u>3/29/69</u> | |
| 22d. PHYSICIAN'S NAME (Type) <u>ROBERT C. DADDARIO</u> | | | | 22e. ADDRESS <u>3413 CEDAR LANE BETHESDA</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>3-31-69</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>FROSTBURG MEMORIAL CEMETERY</u> | |
| 24. FUNERAL DIRECTOR <u>Joseph Robert, Frostburg</u> | | 23d. LOCATION (City or Town) (County) (State) <u>BETHESDA</u> | | 25a. REC'D BY REGISTRAR <u>APR 3 1969</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|--|--|----------------------|---|------------------|--|---|--|---|--|--|----------|---------------------------|--|
| 04169 | | CERTIFICATE OF DEATH | | | | | | 04161 | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Ruth | | | NMN | | McKeehen | | March | | Month 5, Day 1969 Year | | 11:55 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| Female | | White | | August 9, 1985 | | | | 83 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Kansas | | | America | | | | Montgomery Md | | | | | | |
| 1d. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Takoma Park | | | Washington Sanitarium | | | | Nurse | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| Washington D.C. | | | D.C. | | Washington D.C. | | | | 3244 38th Street NW | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | |
| Thomas | | | Stout | | | | | | Lava nis Yoakum | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | |
| no | | | 240-80-5617 | | Patient's chart | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DU TO OR AS A CONSEQUENCE OF <u>GEN. ATHEROSCLEROSIS</u> | | | | | | | | | | MINUTES | | | |
| DU TO, OR AS A CONSEQUENCE OF <u>AGING PROCESS</u> | | | | | | | | | | YEARS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>DIABETES, CORONARY DISSEASE</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-12, 1969</u> to <u>3-5, 1969</u> , that (I) (we) last saw the deceased alive on <u>3-5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>John L. Ford</u> M.D. DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>3/6/69</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>JOHN L. FORD</u> | | | | | | 22e. ADDRESS <u>831 UNIVERSITY BLVD. SEWELL SPRING MD</u> | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| CREMATION | | | March 8, 1969 | | Fort Lincoln Cemetery | | | Cairn Manor Pk. Md. | | | | | |
| 24. FUNERAL DIRECTOR <u>James Funeral Home 254 Carroll St. N.W. Washington, D.C. 20012</u> | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| | | | | | | MAR 10 1969 | | <u>Charles Judge</u> | | | | | |

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VR A15
45M

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 04170 | | | | | | | | 04162 | |
| 1. DECEASED-NAME
(Type or print) <i>William J. McKEEVER JR</i> | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year <i>3-23-69</i> | | 2b. HOUR
<i>8:35 PM</i> | |
| 3 SEX
<i>MALE</i> | | 4 RACE
<i>White</i> | | 5 DATE OF BIRTH
<i>10-24-84</i> | | 6 AGE (In years last birthday)
<i>84</i> YRS | | 7 UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country)
<i>New York</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>U. S A</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>Retired</i> | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
<i>Md.</i> | | 13b COUNTY
<i>Montgomery</i> | | 13c CITY OR TOWN
<i>Catharsburg</i> | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
<i>14025 Millschoice Rd.</i> | |
| 14. FATHER'S NAME
First Middle Last
<i>Charles McKeeven</i> | | | 15 MOTHER'S MAIDEN NAME
First Middle Last | | | Address | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service)
<i>No</i> | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT
<i>Hospital Records</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis & Heart Failure</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Heart Failure</i> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASHP</i> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Small Bowel Obstruction</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Ira Mills, MD</i> | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type)
<i>Ira Mills</i> | | 22e. ADDRESS | | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>cremation</i> | | 23b. DATE
<i>3-26-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Fort Lincoln</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Bladensburg Md.</i> | | 23e. REGD BY REGISTRAR
<i>Charles Judge</i> | |
| 24. FUNERAL DIRECTOR
<i>Ernest C. Gartner</i> | | 24b. ADDRESS
<i>Gartnersburg Md.</i> | | 24c. DATE
<i>MAR 26 1969</i> | | 24d. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

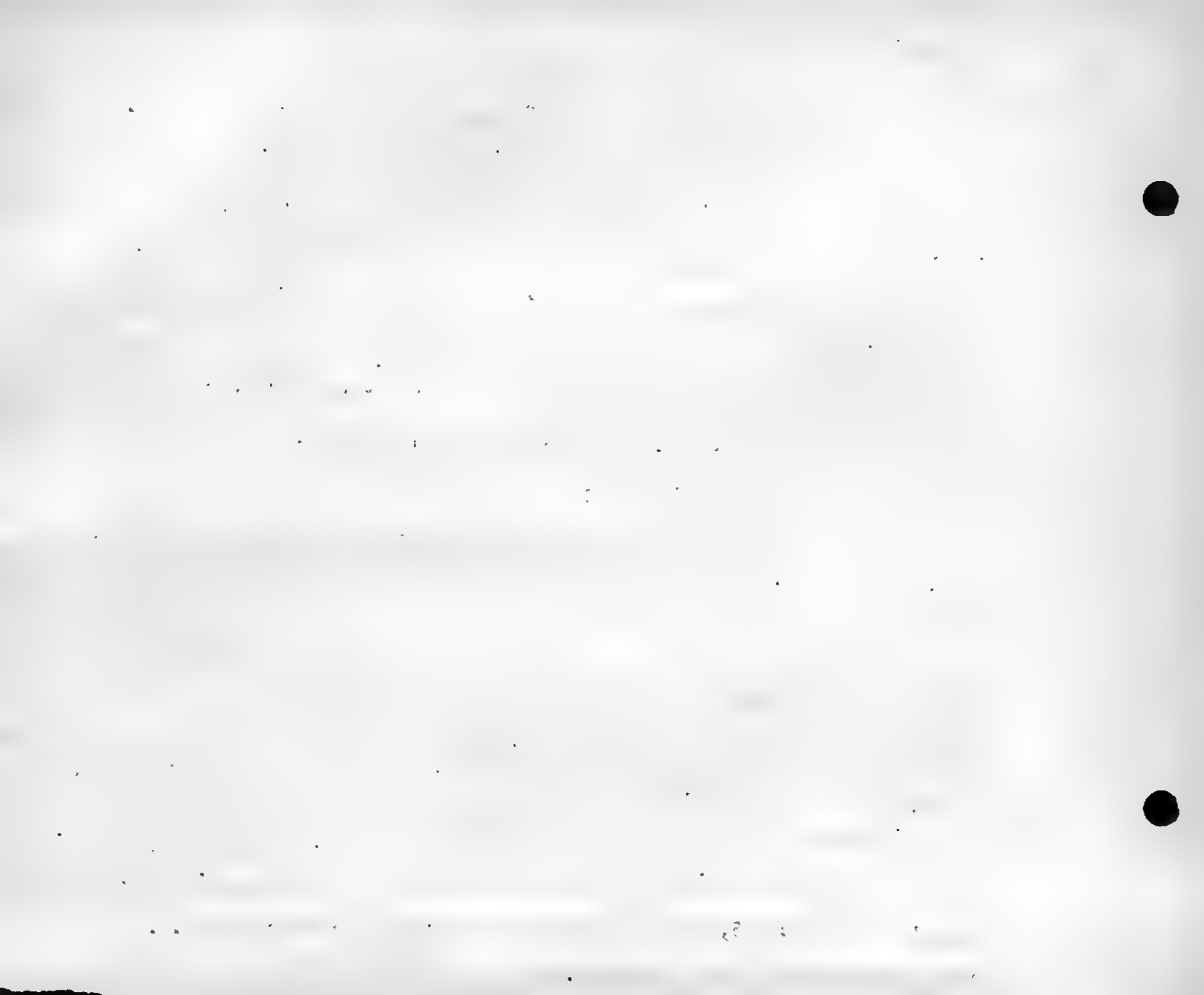
VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04171

04163

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) Sophie Ann McMichael | | | 2a. DATE OF DEATH
Month March Day 11 Year 1969 | | 2b. AM
12:27 |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
26 April 1923 | | 6. AGE (In years last birthday)
45 YRS | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
New Jersey | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE New Jersey COUNTY ✓ | | 13c. CITY OR TOWN
Denville | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
156 Florence Avenue | |
| 14. FATHER'S NAME First Joseph Middle Last Bolcar | | 15. MOTHER'S MAIDEN NAME First Anna Middle Last Bednar | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
144-14-0464 | | 17. INFORMANT Bethesda, Maryland 20814
The Medical Records, The Clinical Center, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Anoxia and Encephalomalacia
7/4 + DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Cardiac Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(c) Congenital Atrial Septal Defect | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Days |
| | | | | | Days |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Bronchopneumonia, Azotemia | | | | | |
| 19a. DATE OF OPERATION
28 Feb. 69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Atrial Septal Defect | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 23 February 1969 , to 11 March, 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11 March 1969 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Edward Jacobs, M.D. | | | 22c. DATE SIGNED
11 March 1969 | | |
| 22d. PHYSICIAN'S NAME (Type) Edward Jacobs, M. D. | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
March 15, 69 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | |
| 23d. LOCATION (City or Town)
East Hanover N.J. | | 23e. COUNTY
Essex | | 23f. STATE
N.J. | |
| 24. FUNERAL DIRECTOR
Loring Byers Chapel 8728 Liberty Rd. 21133 | | 25a. REC'D BY REGISTRAR
MAR 13 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Under | |



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-------------------------------------|--|---|--------------------------------|--|--|------------------------|--|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 04172 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
HUGO NMN MELLA | | | | | | 2a. DATE OF DEATH Month Day Year
MARCH 30, 1969 | | | 2b. HOUR
9:15 PM | | |
| 3 SEX
MALE | | 4. RACE
CAUC | | 5. DATE OF BIRTH
26 FEB., 1888 | | 6. AGE (In years last birthday)
81 YRS | | 7. UNDER 1 YEAR MONTHS | | 7. UNDER 24 HRS. HOURS M.N. | |
| 7a. BIRTHPLACE (State or foreign country)
INDIANA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY | | | Md | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
NAVAL HOSPITAL, BETHESDA | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
U. S. ARMY-RETIRED | | | 12b. KIND OF BUSINESS OR INDUSTRY
PHYSICIAN | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
VIRGINIA | | | 13b. COUNTY
ARLINGTON | | 13c. CITY OR TOWN
ARLINGTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
333 GLEBE RD. | | |
| 14. FATHER'S NAME First Middle Last
GUSTAVE MELLA | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
LOUISE GUGGENHEIM | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
YES | | | 16b. SOCIAL SECURITY NO.
229601137 | | | 17. INFORMANT Address
Gordon W. Mella 805 BRICE RD. ROCKVILLE, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL INFARCTS - SECONDARY TO MURAL THROMBI | | | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF LEFT VENTRICLE | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or RFD No | | | City or Town County State | | |
| 22a. I certify that he (this hospital) attended the deceased from 30 MARCH, 19 69, to 30 MARCH, 19 69, that he (we) last saw the deceased alive on 30 MARCH 19 69 and that in his (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Charles S. Crummy MD | | | | | | 22c. DATE SIGNED 31 MARCH 1969 | | | 22d. PHYSICIAN'S NAME (Type) CHARLES S. CRUMMY MD | | |
| 22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD. | | | | | | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22g. REGISTRAR'S SIGNATURE | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE 4-1-1969 | | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREM. SUITLAND, M.D. | | | 23d. LOCATION (County) S. -- A | | |
| 24. FUNERAL DIRECTOR WASHINGTON, D.C. ADDRESS AVE. JOSEPH GAWLER AND SONS FUNERAL HOME WISCONSIN | | | | | | 25a. RECD BY REGISTRAR DATE APR 7 1969 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
|--|--|----------------------|--|--|--------|--|-------|--|--|-------|-----------------|--|-----------------|--|
| 04173 | | CERTIFICATE OF DEATH | | | | | | | | 04165 | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR P | | |
| Mary | | | Helen | | Melvin | | March | | | Day 2 | | Year 1969 | | |
| 3 SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | | White | | | 26 October 1935 | | | 35 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | |
| Florida | | | USA | | | | | | Montgomery | | | Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | | The Clinical Center | | | housewife | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | | 13e. STREET AND NUMBER | | |
| STATE Maryland | | | Montgomery | | | Chevy Chase | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 7617 Lynn Drive | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | |
| James | | | L. | | McCord | | Ruth | | | Clary | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | The Medical Records Address | | | | | |
| No | | | 262-54-0452 | | | The Clinical Center, NIH, Bethesda, Md. | | | 20014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Right Lung (Widespread metastases)</u> | | | | | | | | | | | | 1 1/2 yrs | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (b) <u>Pulmonary insufficiency</u> | | | | | | | | | | | | 6 weeks | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION | | | Street or R.F.D. No. City or Town County State | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>17 Feb.</u> , 19 <u>69</u> , to <u>2 March</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>2 March</u> , 19 <u>69</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. ADDRESS | | | 22e. REGD. BY REGISTRAR | | | 22f. REGISTRAR'S SIGNATURE | | |
| <u>MB Mosher MD</u> | | | 3 March 1969 | | | The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. REGD. BY REGISTRAR | | | 22f. REGISTRAR'S SIGNATURE | | | | | | | | |
| Michael B. Mosher, MD | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | 3-6-69 | | | Arlington National | | | Arlington Virginia | | | | | |
| 24. FUNERAL DIRECTOR | | | 24a. ADDRESS | | | 24b. DATE | | | 24c. REGISTRAR'S SIGNATURE | | | | | |
| Robert A Pumphrey | | | 7557 Wisconsin Ave
Bethesda, Maryland | | | MAR 5 1969 | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|-----------------------------|--|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 04174 CERTIFICATE OF DEATH 04166 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) CHRISTOPHER Patrick METREY | | | | | | 2a. DATE OF DEATH
Month 3 Day 17 Year 69 | | | 2b. HOUR
5:00 A M | | |
| 3 SEX
male | | 4 RACE
white | | 5. DATE OF BIRTH
3/16/69 | | 6. AGE (in years last birthday)
— YRS. | | 7. UNDER 1 YEAR
MONTHS — DAYS — | | 8. IF UNDER 24 HRS.
HOURS 17 MIN — | |
| 7a. BIRTHPLACE (State or foreign country)
mdc | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md | | 13b. COUNTY mont. | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
12004 Old Bridge Rd. | | | |
| 14. FATHER'S NAME First Richard Middle EVANS Last Metrey | | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Sue Last Sanefeld | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Distress Syndrome | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) 7 | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-16-69 , 19 69 , to 3-17-69 , 19 69 , that (I) (we) lost saw the deceased alive on 3-17-69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert Scanlon MD | | | | | | DEGREE
MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/17/69 | |
| 22d. PHYSICIAN'S NAME (Type)
Robert Scanlon MD | | | | | | 22e. ADDRESS
5406 Conn. Ave. NW Wash. DC. | | | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify)
Burial | | 23b. DATE
3/20/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Md. | | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home | | | | ADDRESS
1331 Rock. Pike Rockville, Md. | | | | 25a. REC'D BY REGISTRAR
MAR 20 1969 | | 25b. REGISTRAR'S SIGNATURE
Opplander Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-68
304 REV 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
|---|--|--|-------------------------|--|---|---|---------------------------------|--|---------------------------------|--|-----------------------------|--------|--|--------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
| 04175 | | | | | | | | | | | | | | | |
| 04167 | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | | | | |
| DINA | | | | | | | Miller | | Month 3 Day 25 Year 69 | | 12 PM | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| Female | | White | | 5-27-06 | | | 62 YRS. | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | |
| Del. | | USA | | | | | Montgomery | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Silver Spring | | Holy Cross Hospital | | | Retired | | | Securities | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | | | |
| MD | | Montgomery | | Silver Spring | | | | 714 Sigsbee Ave | | | | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME: First | | | Middle | | Last | |
| ARTHUR W. | | | | | | | MILLER | | Mary Gertrude | | | | | Dingle | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | | | | | |
| | | | 215-44-3479 | | | Dr. Donald Miller | | | 7911 Jendryk Rd | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary failure | | | | | | | | | | 2 days | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (b) Generalized Carcinomatosis | | | | | | | | | | 1 year | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) Carcinoma of Rt. breast | | | | | | | | | | 3 yrs. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County | | State | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from June 1968, to March 24, 1969, that (1) (we) last saw the deceased alive on March 24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | |
| 22b. SIGNATURE James Coleman MD DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. DATE SIGNED March 25, 1969 | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN MD 22e. ADDRESS 9241 COLUMBIA BLVD MARYLAND | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | | | |
| March 28-1969 | | March 28-1969 | | Bodan Hill Cemetery | | B. Kes. | | Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Arthur Walters | | 254 Carroll St | | APR 1 1969 | | John S. Jones | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| 04176 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04168 | |
|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | |
| HEZEKIAH | | | | | | MILLS | |
| 2a. DATE OF DEATH | | Month | | Day | | Year | |
| MARCH | | 14 | | 69 | | Year | |
| 2b. HOUR | | 9:40 PM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | |
| MALE | | WHITE | | OCT 31, 1884 | | 84 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| MARYLAND | | USA | | | | MONTGOMERY | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| ROCKVILLE | | POTOMAC VALLEY NURSING HOME | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if not last on: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY, IN 157 | |
| MD | | MONTGOMERY | | ROCKVILLE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER | | 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | Address | |
| 13768 TRAVILAH RD | | First Middle Last Charles R. Mills | | First Middle Last Mary | | D.C. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| No | | 217-09-8381A | | Hazel G. Peters- | | 5401 Wehaken Rd. Wash. 16 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | PART 1. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) | | Cardiac Failure | | 2 wks | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | Arteriosclerosis | | 10 yrs | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (c) High & Arteriosclerosis | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-59, to 14 Nov 69, that (I) (we) last saw the deceased alive on 10 Nov 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | |
| William S. Murphy | | | | 615 W. Montgomery Ave., Rockville, Md. | | 14 Nov 69 | |
| 22d. PHYSICIAN'S NAME (Type) | | 23a. B. RIAL, CREMATION, or other (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| | | Burial | | 3/18/69 | | Forest Oak | |
| 24. FUNERAL DIRECTOR | | 23d. LOCATION (City or Town) (County) (State) | | 23e. ADDRESS | | 23f. REGISTRAR'S SIGNATURE | |
| Tyson Wheeler | | Gaithersburg, Montg. Md. | | 1331 Rockville Pike, Rockville, Maryland | | MAR 21 1969 | |

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1

04177

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

64169

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| 1 DECEASED-NAME
(Type or print) <u>DORIS MARGUERITE MILNE</u> | | | First Middle Last | | | 2a. DATE OF DEATH
Month <u>3</u> Day <u>12</u> Year <u>69</u> | | | 2b HOUR
<u>7:40</u> PM | | | | | | | | |
| 3 SEX
<u>FEMALE</u> | | | 4. RACE
<u>WHITE</u> | | | 5. DATE OF BIRTH
<u>9-9-1903</u> | | | 6 AGE (In years last birthday)
<u>65</u> YRS | | | IF UNDER 1 YEAR
MONTHS <u>6</u> DAYS <u>5</u> | | | IF UNDER 24 HRS.
HOURS <u>7</u> MIN. | | |
| 7a BIRTHPLACE (State or foreign country)
<u>MICH</u> | | | 7b CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH
<u>MONTGOMERY</u> Md | | | | | | | | |
| 10 CITY OR TOWN OF DEATH
<u>TAKOMA PARK</u> | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>WASH. SAN. & HOSP</u> | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<u>HOUSE WIFE</u> | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>MD.</u> | | | 13b COUNTY <u>MONT</u> | | | 13c CITY OR TOWN <u>SILVER SPRING</u> | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET AND NUMBER <u>SILVER SPRING 1405 LEISTER DRIVE</u> | | | | | |
| 14 FATHER'S NAME
<u>CURTIS</u> | | | First Middle Last | | | 15 MOTHER'S M A DEN NAME
<u>STELLA GREEN</u> | | | First Middle Last | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <u>NO</u> (If yes give war or dates of serv.) | | | 16b SOCIAL SECURITY NO
<u>579-60-4801</u> | | | 17 INFORMANT <u>J. Scott Milne, Jr.</u> | | | Address <u>Sil. Spr. Md. 12700 Chilton Circle,</u> | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASYSTOLE</u> | | | | | | | | | | | | <u>2 min</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONDUCTION DEFECT</u> | | | | | | | | | | | | <u>?</u> | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>ARTHERO SCLEROSIS</u> | | | | | | | | | | | | <u>30+ yrs</u> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>March</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 12</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Harold M. Swartz, MD</u> | | | DEGREE | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>March 13, 1969</u> | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Harold M. Swartz</u> | | | 22e. ADDRESS
<u>1407 NORTHCREST DR</u> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | | 23b. DATE
<u>March 15, 1969</u> | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Lincoln Crematory</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Bladensburg, Maryland</u> | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Warner E. Pumphrey, Inc.</u> | | | ADDRESS
<u>8434 Georgia Avenue</u> | | | 25a. REC'D BY REGISTRAR
DATE <u>March 19 1969</u> | | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | | |

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VR A15
30M REV. 1-66

| 04178 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04170 | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| First
Lawrence | | Middle
Gustav | | Last
Mohr | | March Month 1 Day 1969 Year 9:00 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
30 October 1909 | | 6. AGE (In years last birthday)
59 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Administrator | | 12b. KIND OF BUSINESS OR INDUSTRY
US Government | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
12220 Glen Mill Road | | 14. FATHER'S NAME
First Middle Last
Gustav L. Mohr | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Selma Auerbach | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> (If yes, give branch of service)
WW II | | 16b. SOCIAL SECURITY NO.
084-09-7042 | | 17. INFORMANT
Bethesda, Maryland 20814
The Medical Records, The Clinical Center, | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c).)
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myelogenous Leukemia</u>
<u>2051</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombocytopenia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>7 Years</u>
<u>1 Month</u> | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>17 February, 1969</u> , to <u>1 March, 1969</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>1 March</u> 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Ervin Epstein, Jr., M.D.</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3 March 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Ervin H. Epstein, Jr., MD. | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-5-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Potomac Methodist Church | | 23d. LOCATION (City or Town) (County) (State)
Potomac, Montgomery County, Md | |
| 24. FUNERAL DIRECTOR
Gawler's Sons, Inc., 1500 Wisc. Ave.
N.W., Wash., D.C., 20016 | | | | 25a. REC'D BY REGISTRAR
DATE MAR 10 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | First (Lynch) Middle M. Last MOORE | | 2a DATE OF DEATH
Month Day Year
Mar. 28, 1969 | | | 2b HOUR
10 A. M. | | |
| 3 SEX
Female | | 4 RACE
Cauc. | | 5 DATE OF BIRTH
June 19, 1889 | | 6 AGE (In years last birthday)
79 YRS. | | F UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country)
Ireland | | 7b CITIZEN OF WHAT COUNTRY?
U. S. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
7103 Clarendon Road | | 12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b COUNTY
Montgomery | | 13c CITY OR TOWN
Bethesda | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
7103 Clarendon Road | |
| 14 FATHER'S NAME First Middle Last
Edward Lynch | | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Mary Nolan | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
No | | 16b SOCIAL SECURITY NO
25-121-126 | | 17 INFORMANT
Daughter Mrs. Mary Wilkinson | | 5603 Lamar Rd., N.W. Washington, D.C. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4409 ARTERIO SCLEROSIS, GENERAL
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 yr. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1966, to 3-28, 1969, that (I) (we) lost soul the deceased alive on 3-27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Leo M. Curtis | | DEGREE
ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-28-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
LEO M. CURTIS | | 22e. ADDRESS
8218 Wisconsin Ave.
Bethesda, Maryland | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b DATE
3-31-69 | | 23c NAME OF CEMETERY OR CREMATORY
St. Joseph's Cemetery | | 23d LOCATION (City or Town) (County) (State)
West Roxbury, Mass. | | | |
| 24 FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a BY REGISTRAR
APR 3 1969 | | 25b REGISTRAR'S SIGNATURE
[Signature] | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 04180 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04172 | |
| Item 13 Film 410 | | 3/14/69 | | kk | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME
(Type or print) First Middle Last
MILWARD F. MOORE | | | 2a. DATE OF DEATH
Month Day Year
MARCH 4 69 | | | 2b. HOUR
12:30 A.M. | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
3-14-84 | | 6. AGE (In years lost birthday)
84 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Ky | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
KETTINGTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
George Moore | | 15. MOTHER'S MAIDEN NAME First Middle Last
Susanne Danner | | 13e. STREET AND NUMBER
none | | 13f. STREET AND NUMBER
none | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
404-14-9685 | | 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>
410.7 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-2</u> , 19 <u>69</u> , to <u>3-4</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3-4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert Kramer M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/4/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS
8984 16th Street Silver Spring Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/6/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Monacacy | | 23d. LOCATION (City or Town) (County) (State)
Beallsville Montg. Md. | |
| 24. FUNERAL DIRECTOR
Hillon Funeral Home Beallsville Md. | | | | 25a. REC'D BY REGISTRAR
MAR 7 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

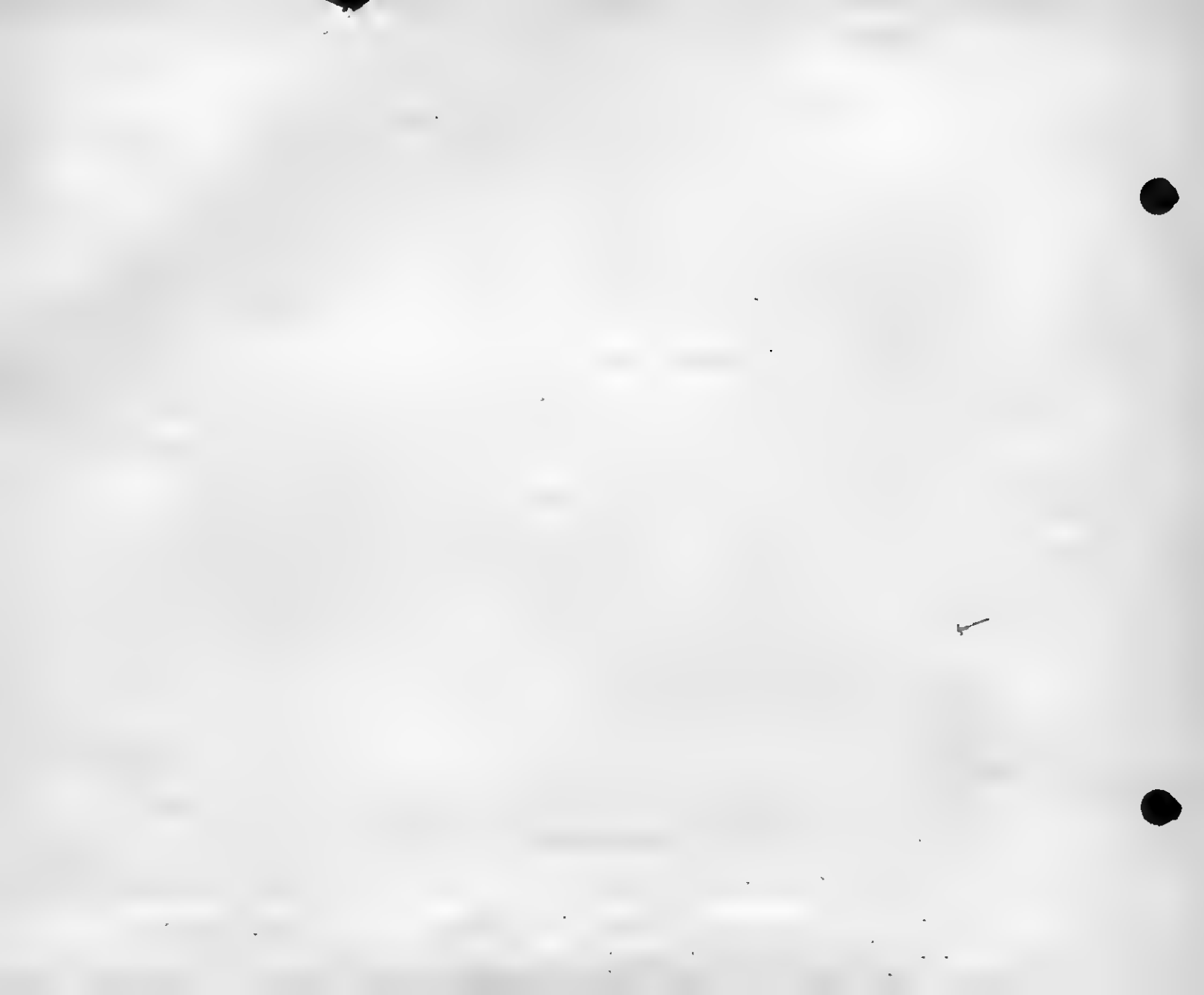
VR A15 (4)
304 REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 04181 | | | | | | | | | | | |
| 04173 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | First
GRACE | | Middle
BESSIE | | Last
MORRIS | | 2a. DATE OF DEATH
Month 3 Day 4 Year 1969 | | 2b. HOUR
5:15 P M | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
5/14/1880 | | 6. AGE (In years
last birthday)
88 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Univ. Nursing Home | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Maid | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USJA. RES DENCE (Where deceased lived, if institution: Residence before
admission) STATE
Wash., DC | | 13b. COUNTY
MD | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
Wash., DC
730 Quebec Pl., NW, | | | |
| 14. FATHER'S NAME
First
? | | Middle
Brown | | Last
Brown | | 15. MOTHER'S MAIDEN NAME First
Jane | | Middle
? | | Last
? | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | (If yes give year or dates of service) | | 16b. SOCIAL SECURITY NO
578-44-4277 | | 17. INFORMANT
Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Encephalomalacia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebral Thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cerebral Arteriosclerosis</u>
CONDITIONS, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Arteriosclerosis Heart Disease</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 19 <u>68</u> , to <u>3/4</u> , 19 <u>69</u> , that (I) (we) last
saw the deceased alive on <u>3/4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>L. Cannaday</u> | | 22c. DATE SIGNED
3/4/69 | | 22d. PHYSICIAN'S
NAME (Type)
Dr. L. Cannaday/Dibble | | 22e. ADDRESS
3632 Georgia Ave., NW, Wash., DC | | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22g. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | 23b. DATE
3-8-69 | | 23c. NAME OF CEMETERY OR CREMATORY
HARMONY MEM. PK. | | 23d. LOCATION (City or Town)
LANDOVER | | (County)
PRINCE GEORGE'S | | (State)
MD. | |
| 24. FUNERAL DIRECTOR
BETAYLOR | | 24a. ADDRESS
909 GUYTON, W. D.C. | | 25a. REC'D BY REGISTRAR
DATE MAR 10 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) First Middle Last
<i>Joseph H. Murdock</i> | | | | | 2a DATE OF DEATH Month Day Year
<i>3-15-69</i> | | | 2b HOUR
<i>3:30 PM</i> | | |
| 3 SEX
<i>Male</i> | | 4 RACE
<i>White</i> | | 5 DATE OF BIRTH
<i>9-16-29</i> | | 6 AGE (In years last birthday)
<i>74</i> YRS | | IF UNDER 24 HRS MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (State, or foreign country)
<i>Wash D.C.</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>U.S.A</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
<i>Montgomery</i> | | | | |
| 10 CITY OR TOWN OF DEATH
<i>Bethesda</i> | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Retired</i> | | 12b KIND OF BUSINESS OR INDUSTRY
<i>Railroad</i> | | |
| 13a USUAL RESIDENCE (Where deceased lived, if instituting on Residence before admission) STATE
<i>Md.</i> | | | 13b COUNTY
<i>Montgomery</i> | | 13c CITY OR TOWN
<i>Silver Sp.</i> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
<i>9915 Indian Lane</i> | |
| 14. FATHER'S NAME First Middle Last
<i>David B. Murdock</i> | | | 15 MOTHER'S MAIDEN NAME First Middle Last
<i>Annie E. Williams</i> | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war and dates of service)
<i>No</i> | | | 16b SOCIAL SECURITY NO
<i>136</i> | | 17 INFORMANT Address
<i>Joseph B. Murdock 9915 Indian Lane SS</i> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCTION - RECENT - REMOTE</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>CORONARY ARTERIOSCLEROSIS & THROMBOSIS</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Ruptured abdominal aortic aneurysm</i> | | | | | | | | | | |
| 19a DATE OF OPERATION
<i>2/14/69</i> | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>aortic aneurysm</i> | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year
<i>19</i> | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f LOCATION Street or RFD No City or Town County State | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>2/14</i> , 1969, to <i>3/15</i> , 1969, that (I) (we) last saw the deceased alive on <i>3/15</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
<i>Joseph F. Schanno</i> | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED
<i>16 Mar 69</i> | | | | |
| 22d PHYSICIAN'S NAME (Type)
<i>Joseph F. Schanno</i> | | | | 22e ADDRESS
<i>8218 Old Lincoln Ave. Beltsville</i> | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b DATE
<i>March 18/1969</i> | | 23c NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Cemetery</i> | | 23d LOCATION (City or Town) (County) (State)
<i>Suitland, Maryland</i> | | | | |
| 24 FUNERAL DIRECTOR
<i>Warner E. Humphrey</i> | | | | ADDRESS
<i>8434 Georgia Avenue Silver Spring, Maryland</i> | | 25a REC'D BY REG STRAR
<i>Mar 20 1969</i> | | 25b REG STRAR'S SIGNATURE
<i>Charles Judge</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tags, papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

Item 6 Film 10 3/12/69 kk

| | | | | | |
|---|---|--|--|--|---|
| 1 DECEASED NAME
(Type or print) Blanche R Murphy | | | 2a. DATE OF DEATH
Month March Day 3 Year 69 | | 2b. HOUR
11:50 PM |
| 3 SEX
Female | 4 RACE
N | 5. DATE OF BIRTH
1-19-31 | | 6 AGE (In years last birthday)
38 YRS | 7. UNDER YEAR
MONTHS 11 DAYS 27 |
| 7a. BIRTHPLACE (State or foreign country)
Tenn. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md | | |
| 10 CITY OR TOWN OF DEATH
Wheaton, Md | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
University Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
cab driver | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE
Washington, D.C. | 13b. COUNTY
D.C. | 13c. CITY OR TOWN
Washington, D.C. | 3d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
237 Mississippi Ave | |
| 4 FATHER'S NAME First Milton Middle Murphy Last | 15 MOTHER'S MAIDEN NAME First Codessa Middle Daley Last | | Address | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO
6-18 44 7111 | 17 INFORMANT
Mary Tibbs 101 16th St NW Wash DC | | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic carcinoma
DUE TO, OR AS A CONSEQUENCE OF uterine (cervical) carcinoma
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year
unknown |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/26 , 19 68 , to Mar 4 , 19 69 , that (I) (we) last saw the deceased alive on Mar 1 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Henry G. Hadley, M.D. | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
2-4-69 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS
4601 Nichols Avenue, S. W | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE
3/7/69 | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Mem Cem | | 23d. LOCATION (City or Town) (County) (State)
Highland Park, Md. | |
| 24. FUNERAL DIRECTOR
Petworth Funeral Home | | ADDRESS
814 Upshur St. N/W | | 25a. REC'D BY REGISTRAR
MAR 7 1969 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04184

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04176

| | | | | | | | | | | | | | |
|--|--|------------------|---|---|--|--|--|--|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) <i>Raymond B Murray Jr.</i> | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH Day Year <i>Mar. 7 1969</i> | | | | 2b. HOUR <i>10:30</i> - M | | | |
| 3. SEX <i>M</i> | | 4. RACE <i>W</i> | | 5. DATE OF BIRTH <i>Dec. 9 - 1908</i> | | 6. AGE, in years (last birthday) <i>50</i> YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month Day Year <i>Mar. 7 1969</i> | | 2d. HOUR <i>10:30</i> - M | |
| 7a. BIRTHPLACE (State or foreign country) <i>Conn.</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Montgomery</i> Md | | | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Sidney Hill</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>U.S.A. Research & Development</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if not in institution residence before admission) STATE <i>Maryland</i> | | | | 13b. COUNTY <i>Mont.</i> | | 13c. CITY OR TOWN <i>Bethesda</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>5011 Euclid Ave.</i> | | | |
| 14. FATHER'S NAME
First Middle Last <i>Raymond B Murray</i> | | | 15. MOTHER'S M A D E N NAME
First Middle Last <i>Helen Zimmerman</i> | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i> | | | | 16b. SOCIAL SECURITY NO. <i>517-12-0028</i> | | 17. INFORMANT <i>Kecalia M. Murray</i> | | | | ADDRESS <i>Same as above</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i>
<i>4119</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Sudden</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <i>19</i> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John S. Ball</i> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED <i>Mar 7, 1969</i> | | | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE <i>3-11-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN CEMETERY</i> | | | | 23d. LOCATION (City or Town) (County) (State) <i>SILVER SPRING, MARYLAND</i> | | | |
| 24. FUNERAL DIRECTOR <i>Francis J. Collins 500 Univ. Blvd. W.</i> | | | | 25a. REG'D BY REGISTRAR <i>MAR 12 1969</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove green papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04185

CERTIFICATE OF DEATH

04177

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(Type or print) MABEL S. NASH | | | 2a. DATE OF DEATH
Month 03 Day 19 Year 1969 | | | 2b. HOUR
2 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
SEPT. 23, 1888 | | 6. AGE (in years last birthday)
80 YRS | |
| 7a. BIRTHPLACE (State or foreign country)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY COUNTY Md. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
CHEVY CHASE NURSING HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
AT HOME | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
WASH. D.C. | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
3617 QUESADA ST. | | 14. FATHER'S NAME
First JAMES Middle WHITE Last ELIZABETH | | 15. MOTHER'S MAIDEN NAME
First ELIZABETH Middle CARROLL Last | | | |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
NO | | 16b. SOCIAL SECURITY NO
578 44-1333 | | 17. INFORMANT
JAMES NASH, SON, SAME AS ITEM #13 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4379 Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration & Atelectasis, Chronic Brain Sydn
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis & Senile Psychosis | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeks
2 months
5 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1955 , 19____, to March 19, 1969 , that (I) (we) last saw the deceased alive on 3/9 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Paul F. Jaguel, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/19/69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Paul F. Jaguel, M.D. | | | | 22e. ADDRESS
3701 Mass. Ave. N.W. Wash. D.C. USA | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-21-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Montgomery Co. Md. | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016 | | | | 25a. REC'D BY REGISTRAR
DATE MAR 26 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| Item 13 See birth cert. am. Maryland State Department of Health | | | | | | | | | | | |
|---|--|--|-------------------------|--|--------|--|--------------------------------|--|-------------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month Day Year | | |
| 04186 | | | | | | | Naugle | | 3 27 69 | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | | 6 AGE (In years lost birthday) | | 2b. HOUR | | |
| Female | | Caucasian | | 3-27-69 | | | — YRS | | 545 M | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | |
| Maryland | | USA | | | | Montgomery | | Silver Spring | | Holy Cross | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Maryland | | Montgomery | | Rockville | | | | 5017 Naples Avenue | | None | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | |
| William W. | | | Naugle | | | | Charlene | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | |
| NA | | | NA | | | NA | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Spontaneous</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| NA | | NA | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | 19 | | NA | | | | | | | |
| 21d. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION | | Street or R.F.D. No | | City or Town | | County | | State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | NA | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/27/69 4:55 P.M. to 3/27/69 5:45 P.M., that (I) (we) last saw the deceased alive on 3/27/69 5:45 P.M., and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| Richard J. Hollander | | 3/28/69 | | | | Richard J. Hollander | | 1110 Spring Street, Silver Spring, Md. | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | 23e. LOCATION (County) | | 23f. LOCATION (State) | |
| Buried | | 4/1/69 | | Gate of Heaven | | Silver Spring | | Montgomery | | Md. | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Tyson Wheeler Funeral Home 151 Rock Pike Rockville, Maryland | | | | APR 7 1969 | | | | Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04187

Item 13 Film 411 4/2/69 kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04179

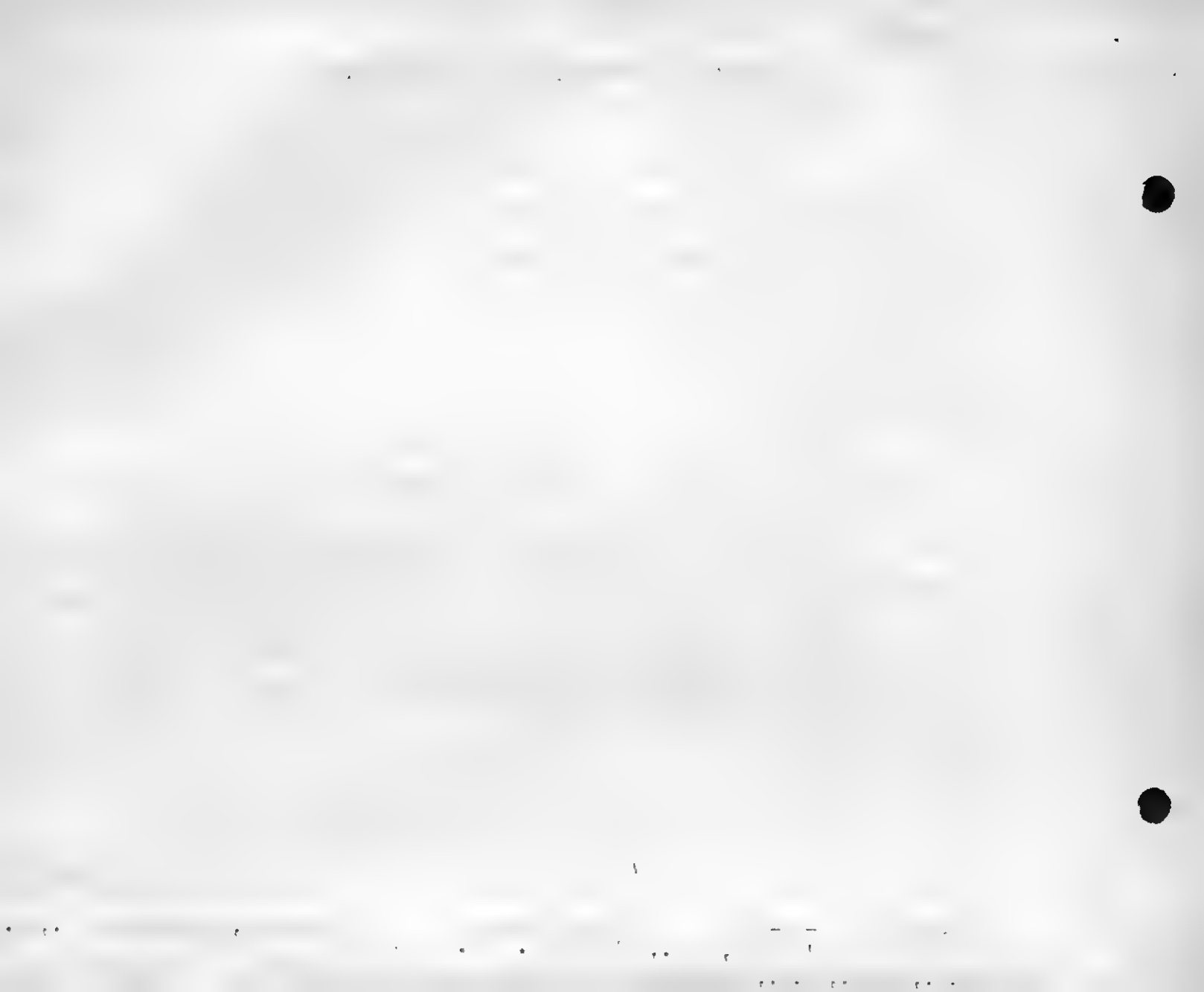
| | | | | | | | | |
|--|---------|--|------------------|--|---------------------------------|--|-----------------------|--|
| 1. DECEASED NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| ROSE | | | | NELSON | March Month 20 Day 1969 Year | | 12 ¹³ P.M. | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Female | White | | May 10, 1882 | | 86 YRS | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Unknown | | US | | | | Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Germantown | | Marylander Nursing Home | | Housewife | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET AND NUMBER | | |
| Maryland | | Montgomery | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | Arden Road R.F.D. Germantown, Md. | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | First Middle Last | | | | | | |
| Unknown | | Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | |
| No | | 577-30-3835 | | Marylander Nursing Home-Germantown, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> | | | | | | | | 10 minutes |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | |
| (b) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | years |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>63</u> , to <u>20 March</u> , 19 <u>69</u> , that (I) do not <u>do</u> saw the deceased alive on <u>20 March</u> , 19 <u>69</u> , and that in (my own <u>own</u>) opinion death occurred on the date and hour and from the causes stated above, (I) do <u>did</u> view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| <u>Gordon Murdoch Smith, MD</u> | | | | | | 20 March 69 | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | |
| <u>Gordon Murdoch Smith, MD</u> | | <u>Barnesville, Md 20703</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 3/25/69 | | Glenwood | | Washington, D.C. | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u> | | MAR 26 1969 | | <u>[Signature]</u> | | | | |
| Rockville, Md. | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|---------------|--|--|-------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 04188 | | 04180 | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | First Elizabeth Middle Bennett Last Nettleship | | | DATE OF DEATH | | | 2b HOUR | |
| Elizabeth BENNETT NETTleship | | | | | MAR. 8 1969 | | | 2 1/2 A M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 UNDER 1 YEAR | |
| Female | | White | | 10-11-1890 | | 78 | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | 10 UNDER 24 HRS | |
| DASH D.C. | | U.S.A. | | | | Montgomery | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTE (street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BETHESDA | | Suburban Hospital | | At Home | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| Maryland | | Montgomery | | Cherry Chase | | | | 5700 Dorset Ave. | |
| 14 FATHER'S NAME First Middle Last | | 15 MOTHER'S MAIDEN NAME First Middle Last | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Address | |
| William A Bennett | | Martha White | | NO | | 577-05-7150 | | MRS. RICHARD E. CARPENTER, DAUGHTER | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) | | PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| H110 | | Myocardial Infarction | | | | 8 days | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | (b) Anterograde Heart Disease | | DUE TO, OR AS A CONSEQUENCE OF | | years | | | |
| | | (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| Arteriosclerotic Cardiovascular Disease - Cerebral Thrombosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County State | |
| | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 3/1, 1969, to 3/8, 1969, that (I) (we) last saw the deceased alive on 3/8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE | | 22c. DATE SIGNED | | 22d PHYSICIAN'S NAME (Type) | | | | | |
| Richard H. Pollen MD | | 3/8/69 | | RICHARD H. POLLEN | | | | | |
| 22e ADDRESS | | 22f. REC'D BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | | | | | |
| 10400 CONNECTICUT Ave, Kensington Md. | | MAR 14 1969 | | Charles Judge | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3-11-1969 | | Parklawn Cemetery | | Rockville, Montgomery Co., Md. | | | |
| 24 FUNERAL DIRECTOR | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | |
| Joseph Gawler's Sons, Inc., 3120 Wisc. Ave. N.W., Wash., D.C., 20016 | | MAR 14 1969 | | Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|--|---|--|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR |
| SARAH ELIZABETH NURWOOD | | | | | | MARCH 28, 1969 | | | 6:25 P.M. |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 7. IF UNDER YEAR MONTHS DAYS | |
| FEMALE | WHITE | | 3-27-06 | | | 63 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| MARYLAND | | | AMERICA | | | | MONTGOMERY, Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| TAKOMA PARK | | | WASHINGTON SAN. & HOSP. | | | Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before adm-ssion) STATE | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MARYLAND Carroll | | | HT. AIRY | | | | 307 CARROLL AVENUE | | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| EDWARD BOWMAN | | | MARY JONES | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | |
| No | | | | | HOSPITAL RECORDS, TAKOMA PARK, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 1. Central motor cortex | | | | | | | | | |
| 2. Curricular carcinoma | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15/69 to 8/28/69, that (I) (we) last saw the deceased alive on 8/28/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | |
| Lewis William Dennes | | | 8/28/69 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | |
| Lewis William Dennes | | | 8906 Red Bull Rd. Silver Spring, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | April 1, 1969 | | Damascus Meth. | | Damascus, Md. | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Olin L. Molesworth, Damascus, Md. | | | | | | APR 3 1969 | | Charles Judge | |

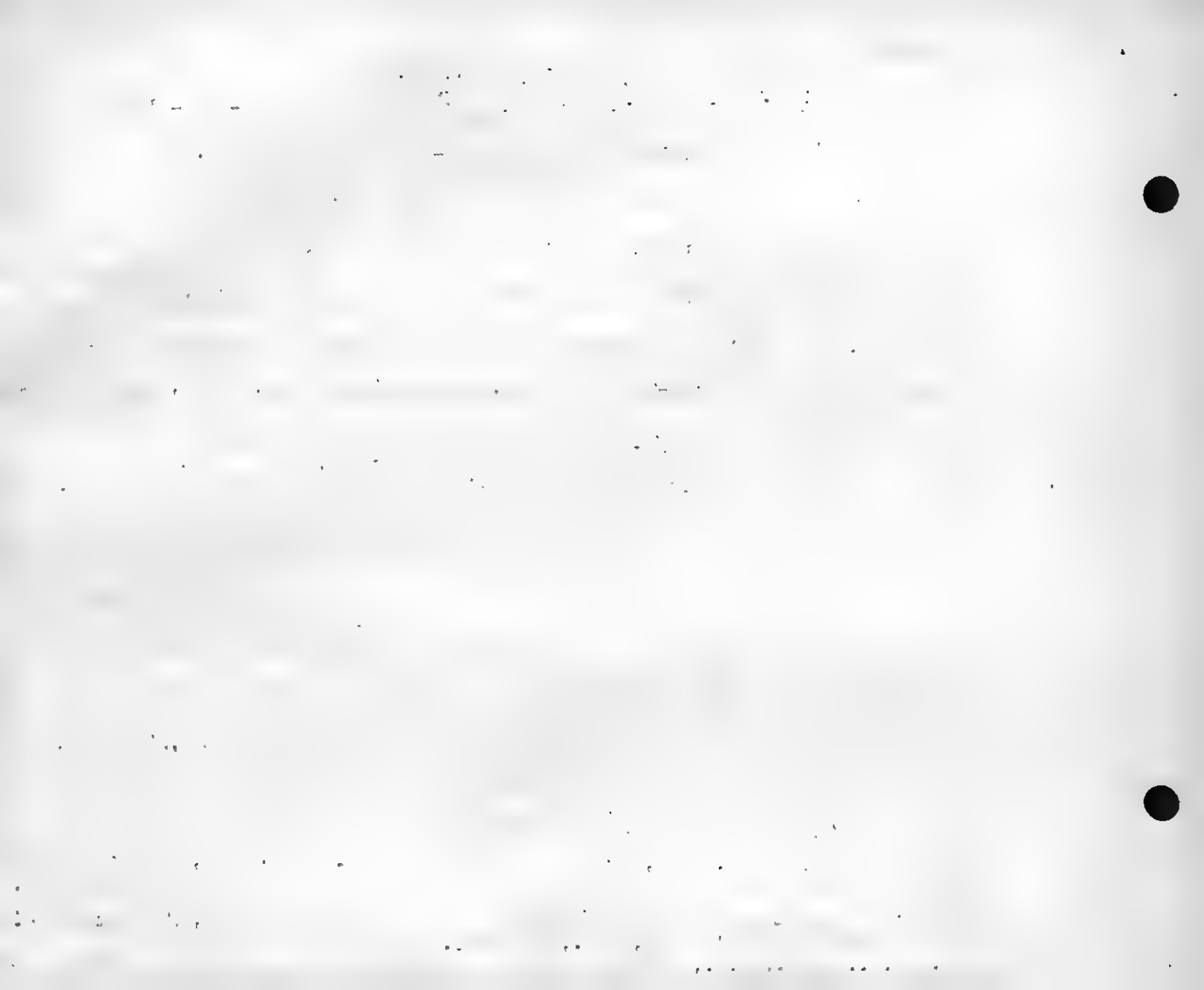


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A154
30M REV. 1968

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|--|
| 04190 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) Loyal | | | First LOYAL Middle IRVING Last NUTTING | | | 2a. DATE OF DEATH
Month 3 - Day 26 - Year 1969 | | | 2b. HOUR 3:30 P | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5. DATE OF BIRTH
11-22-1901 | | | 6 AGE (n years
last birthday)
67 yrs. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (State or foreign
country) New York | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Montgomery General Hospital | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) Broker | | | 12b. KIND OF BUSINESS OR
INDUSTRY Stock | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Maryland | | 13b. COUNTY Howard | | 13c. CITY OR TOWN
Columbia | | 13d. INSIDE CITY, WANTS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 10850 Green Mount
tain Circle, #211 | | | | |
| 14 FATHER'S NAME First J. Middle Cole Last Nutting | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Cecelia Last Walsh | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no | | (If yes give year or dates of service) | | 16b. SOCIAL SECURITY NO
367-05-3520A | | 17. INFORMANT
Address #13
Mrs. Ada Devlin Nutting, Widow, same as item | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Coronary occlusion | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (b) Cardiovascular ht. dis. | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) 5 years | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> TOP CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. 19 Month 1 Day 19 Year 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. 3/26 City or Town 1969 County 1969 State 1969 | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Dec 1, 1968 to 3/26, 1969 , that (I) (we) last
saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Christian S. Mass, MD | | 22c. DATE SIGNED
3/27/69 | | 22d. PHYSICIAN'S
NAME (Type) Christian S. Mass, MD | | 22e. ADDRESS
#21 South St. Johns Lane, Ellicott City | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
3-29-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Montgomery Co. Md. | | | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., 5130 Wis.
Ave., N.W., Wash., D.C., 20016 | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|--|--|--|--|--|
| 04183 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 04183 | |
| Item 8 Film 0410 3/14/69 kk | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME
(Type or print) <i>Almeda M Edwards O'Donnell</i> | | | 2a. DATE OF DEATH
Month <i>March</i> Day <i>11</i> Year <i>1969</i> | | 2b. HOUR
<i>7:15</i> M |
| 3 SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
<i>7/10/1899</i> | | 6 AGE (In years last birthday)
<i>79</i> YRS | 7. FUNDER YEAR
MONTHS <i>7</i> DAYS <i>11</i> HOURS <i>15</i> MIN |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>St. Hubert Hosp</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i> | | 13b. COUNTY
<i>Montgomery</i> | 13c. CITY OR TOWN
<i>New York</i> | 13d. INSIDE CITY <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<i>455 Indian City Place</i> |
| 14. FATHER'S NAME First <i>Silas</i> Middle <i>Carter</i> Last <i>Edwards</i> | | 15. MOTHER'S MAIDEN NAME First <i>Martha</i> Middle <i>Louise</i> Last <i>Papin</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
<i>DR. Daniel Blumsky</i> | |
| 18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>EMG 7/10/69 10:00 PM</i>
DUE TO OR AS A CONSEQUENCE OF (c) <i>CARDIO VASCULAR RENAL DISORDER</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>11 HRS</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR <i>10</i> A.M. Month <i>3</i> Day <i>13</i> Year <i>1969</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or RFD No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/10</i> , 1964, to <i>3/10</i> , 1964, that (I) (we) last saw the deceased alive on <i>3/9</i> , 1964, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | |
| 22b. SIGNATURE
<i>A. J. Brennan MD</i> | | 22c. DATE SIGNED
<i>3/10/69</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>A. J. Brennan</i> | |
| 22e. ADDRESS
<i>Bethesda, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>3-13-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Wooster Cemetery</i> | |
| 23d. LOCATION (City or Town)
<i>Danbury</i> | | 23e. (County)
<i>Conn.</i> | | 23f. (State) | |
| 24. FUNERAL DIRECTOR
<i>Robert A. Bingham</i> | | ADDRESS
<i>7537 Wisconsin Ave</i> | | 25a. REC'D BY REG. STRAR
<i>MAR 12 1969</i> | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS
45M - 100

| 04192 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04184 | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|------------------------------|--|--|--|--|-------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (Type or print) HELEN BRYAN OEHMANN | | | | | | | | | | 2a. DATE OF DEATH March 9 1969 | | | | | | | | | | 2b. HOUR 7:34 AM | | | | | | | | | |
| 3 SEX Female | | | 4 RACE White | | | 5. DATE OF BIRTH July 30, 1918 | | | 6. AGE (In years last birthday) 50 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | IF UNDER 24 HRS
HOURS MIN | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) North Carolina | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Montgomery | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10831 EASTWOOD AVE | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Secretary | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland | | | 13b. COUNTY Montgomery | | | 13c. CITY OR TOWN Silver Spring | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 10831 Eastwood Ave. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First J. Middle S. Last Bryan | | | 15. MOTHER'S MAIDEN NAME First Helen Middle Broughton Last Broughton | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO 578-14-9116 | | | 17. INFORMANT John B. Oehmann Address 10831 Eastwood Silver Spring | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction
2400
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 YRS | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 22, 1968 to Mar 9, 1969 , that (I) (we) last saw the deceased alive on Mar 4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE Bernard A. Fitzgerald MD DEGREE MD ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 22c. DATE SIGNED 3-9-69 | | | 22d. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD | | | 22e. ADDRESS 27440 Blvd E, Silver Spring Md | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE Mar. 12, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | | | 23d. LOCATION (City or Town) (County) (State) Silver Spring, Md. | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Francis J. Collins, 500 University Blvd., West Silver Spring, Maryland | | | 25a. REC'D BY REGISTRAR MAR 12 1969 | | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 04193 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04185 | |
|---|---|---|--|---|----------------------------------|---|------------------------------------|
| 1 DECEASED NAME
(Type or print) | | | | First | Middle | Last | 2a DATE OF DEATH
Month Day Year |
| Anna Bohrer Offutt | | | | | | | March 30 1969 3 P.M. |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | 7 F UNDER 1 YEAR
MONTHS DAYS | | 8 F UNDER 24 HRS
HOURS M.N. |
| female | white | 6-19-83 | | 85 YRS | | | |
| 7a BIRTHPLACE (State or foreign country) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 COUNTY OF DEATH | | | | |
| Maryland | U.S.A. | Montgomery | | | | | |
| 10 CITY OR TOWN OF DEATH | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during last of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | Suburban Housewife | | Housewife | | Private | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institut an admission) STATE | 13b COUNTY | 13c CITY OR TOWN | 3a DISTRICT CITY, M.D. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER | | | |
| MD | Montgomery | Bethesda | | 7824 - Glenbrook Rd. | | | |
| 14 FATHER'S NAME First Middle Last | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| Charles Bohrer | | Annie R. Hodges | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | 16b SOC AL SECURITY NO | | 17 INFORMANT Address | | | |
| no | | 574-07-6891 | | Marie Peterson 1113 - Glenbrook Rd. Kensington Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Atherosclerotic Heart Disease | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) 10 years | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At home farm street factory, office building etc) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a I certify that (I) (this hospital) attended the deceased from February 19 55 to Mar 30 1964, that (I) (we) last saw the deceased alive on Mar 30 1964, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE | | 22c DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22d DATE SIGNED | | | |
| Michel M. HEALY, MD | | 5411 W. Cedar La, Bethesda Md. | | 3/30/69 | | | |
| 23a BURIAL CREMATION REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | |
| Burial | | 4/2/69 | | Rockville Cemetery | | Rockville, Montgomery Md. | |
| 24 FUNERAL DIRECTOR | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| Tyson Wheeler Funeral Home Rockville, Md. | | APR 7 1969 | | J Charles Judge | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|----------------------|--|---|--|---|--|--|--|--|
| <div>04194</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>04186</div> | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) <u>Katherine A Parent</u> | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>March</u> Day <u>5</u> Year <u>1969</u> | | 2b. HOUR <u>12:35</u> PM | |
| 3. SEX <u>Female</u> | 4. RACE <u>White</u> | 5. DATE OF BIRTH <u>2/14/07</u> | 6. AGE (In years last birthday) <u>62</u> YRS | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | IF UNDER 24 HRS HOURS _____ MIN _____ | 2c. DATE PRONOUNCED DEAD Month <u>March</u> Day <u>5</u> Year <u>1969</u> | | 2d. HOUR <u>12:35</u> PM | |
| 7a. BIRTHPLACE (State or foreign country) <u>Massachusetts</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Montgomery</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hosp</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Grant Advisor</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov. NIH</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md</u> | | | 13b. COUNTY <u>Mont</u> | | 13c. CITY OR TOWN <u>Bethesda</u> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER <u>16509 Montrose Ave</u> | | |
| 14. FATHER'S NAME First <u>O.</u> Middle <u>N.</u> Last <u>Parent</u> | | | 15. MOTHER'S MAIDEN NAME First <u>Grace</u> Middle <u>Gertrude</u> Last <u>Bussell</u> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | |
| | | | 16b. SOCIAL SECURITY NO <u>162-10-4701</u> | | 17. INFORMANT <u>Mr. David E. Parent, 135 Chesnut St. Richmond Hgts. Ohio</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion.</u>
<u>4109</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Coronary Arterio Sclerosis -</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | <u>2 yrs.</u>

<u>years.</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Lobar Pneumonia, Left Lung</u> | | | | | | | | | |
| 19a. DATE OF OPERATION _____ | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ | | | 21b. TIME OF INJURY Month, Day, Year _____ HOUR A.M. _____ P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____ | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) _____ | | | 21f. LOCATION Street or RFD No _____ City or Town _____ County _____ State _____ | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <u>March 5, 1969</u> | | | |
| EXAMINER'S NAME (Type) <u>JOHN G. BALL, MD.</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Montgomery Co. Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE <u>3-8-69</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Rockville, Montg. Co. Md.</u> | | |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | | | | 25a. REC'D BY REGISTRAR <u>MAR 12 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 04187 | |
|---|-----------------|---|--|--|--------------------------------|---|---|---|---|----------------------------------|-----------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED-NAME
(Type or Print) | | | First
WILLIAM | | Middle
V. | | Last
Pastor | | 2a DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> Month 3 Day 3 Year 1969 | | 2b HOUR
7A M |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH
12/17/-3 | 6 AGE (in years last birthday)
65 YRS | IF UNDER YEAR
MONTHS 2 DAYS 16 | | F UNDER 24 HRS
HOURS MIN. | | 2c DATE PRONOUNCED DEAD
Month 3 Day 3 Year 1969 | | 2d HOUR
7A M | |
| 7a BIRTHPLACE (State or foreign country)
Rumania | | 7b CITIZEN OF WHAT COUNTRY?
USA/Canada | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Montgomery | | | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring Md. | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
Holy Cross Hospital | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Security Guard - New York and Emb. | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USJA: RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Maryland | | | 13b COUNTY
Montgomery | | 13c CITY OR TOWN
Kensington | | 13d INSIDE CITY, MTS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
11528 Soward Dr. Kens Md. | | |
| 14 FATHER'S NAME
First Julius Middle Pastor Last | | | 15 MOTHER'S MAIDEN NAME
First R. se Middle Sta. ish Last | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) none (If yes give war or dates of service) | | | | | |
| 16b SOCIAL SECURITY NO
none | | | 16c SOCIAL SECURITY NO
10 e | | | 17 INFORMANT
wife Beatrice L 11528 Soward Dr., Kensington Md. | | | ADDRESS
Silver Spring Md. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>White Coronary Insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last }
(b) <u>Coronary Artery Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b DATE SIGNED
March 3, 1969 | | |
| EXAMINER'S NAME (Type)
Belden R. Reap, M.D. | | | ADDRESS
4431 Georgia Avenue | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
March 6, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Maryland | | |
| 24 (FUNERAL DIRECTOR'S NAME)
Harne E. Purhrey, Inc. Silver Spring, Md. | | | | | | 25a REC'D BY REGISTRAR
MAR 7 1969 | | | 25b REGISTRAR'S SIGNATURE
Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|--|---|---|---|------------------------|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month | | Day | Year | 2b. HOUR | |
| EMILY R. PECK | | | | | | MARCH | | 18 | 1969 | 12:30 PM | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| FEMALE | | CAUCASIAN | | 6/22/75 | | 93 YRS | | MONTHS | | HOURS | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| WASH D.C. | | U.S. | | | | MONTGOMERY MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| CHEVY CHASE | | | BETHESDA - SILVER SPRING NURSING HOME | | | Homemaker - own home | | | INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | | |
| MD | | | MONTGOMERY | | SILVER SPRING | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8505 SPRINGVALE ROAD | | |
| 14. FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Edward S. Peck | | | Katherine Raymond | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT | | | Address | | |
| NO | | | 579-60-1612 | | | J1 PHILIP PECK | | | 3411 TURNER LANE CHEVY CHASE, MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4409 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | 4-5 MONTHS | |
| (b) ATHEROSCLEROSIS | | | | | | | | | | SEVERAL YEARS | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 12/68 | | CATARACT | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At home farm street, factory, office building, etc.) | | 21f LOCATION Street or RFD No City or Town County State | | | | | | | |
| | | | | | | | | | | | |
| 22a I certify that (1) (this hospital) attended the deceased from 2/10, 1966, to 3/18, 1969, that (1) (we) last saw the deceased alive on 3/18/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b SIGNATURE | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED | | |
| James A. Roberts | | | | | | | | | 3/18/69 | | |
| 22a PHYSICIAN'S NAME (Type) | | | | | 22e ADDRESS | | | | | | |
| JAMES A. ROBERTS | | | | | 6907 GEORGIA AVE. SILVER SPRING MARYLAND | | | | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | | |
| Cremation | | 3-18-69 | | Cedar Hill Crematory | | | Suitland, Maryland | | | | |
| 24 FUNERAL DIRECTOR | | | | | ADDRESS | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| ROBERT A. PUMPHREY, Bethesda, Maryland | | | | | | | | MAR 24 1969 | | William J. J. J. | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | First | | Middle | | Last | | 2c. DATE OF DEATH | |
| Manuel | | | | Peon | | | | Mar 18 1969 | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 UNDER 24 HRS | |
| MALE | | White | | 11/10/04 | | 64 YRS | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | 10 UNDER 24 HRS | |
| Cuba | | U.S. | | | | Montgomery | | MONTHS DAYS HOURS MIN | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Silver Spring | | Fairland Nursing Home | | STORE OWNER | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INS DE CITY, H 15? | | 13e STREET AND NUMBER | |
| Md | | Montgomery | | TAKOMA PARK | | NO | | 506 Dimer Ave | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15 MOTHER'S MAIDEN NAME | |
| Manuel | | A | | Peon | | | | LOUISA | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b SOC AL SECURITY NO | | 17 INFORMANT | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| NO | | 265-74-677 | | EMMA VASALLO 1024 University Blvd. East | | PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral of Brain</u> | | 2 yrs | |
| | | | | | | (b) DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | | | (c) DUE TO, OR AS A CONSEQUENCE OF | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f LOCATION | | City or Town | | County State | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or R.F.D. No. | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> , 19 <u>68</u> , to <u>3/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | | |
| Raymond T. Benack MD | | 3/19/69 | | Raymond T. Benack MD | | | | | |
| 22e ADDRESS | | 22f ADDRESS | | | | | | | |
| | | 4115 Blue Drive, Wheaton, Md | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | 23e COUNTY (County) | |
| BURIAL | | 3-21-69 | | Rock Creek Cemetery | | Washington | | D. C. | |
| 24 FUNERAL DIRECTOR | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| FRANCIS J. COLLINS | | | | 500 University Blvd. W. Silver Spring, Md. | | MAR 24 1969 | | Charles J. Jordan | |

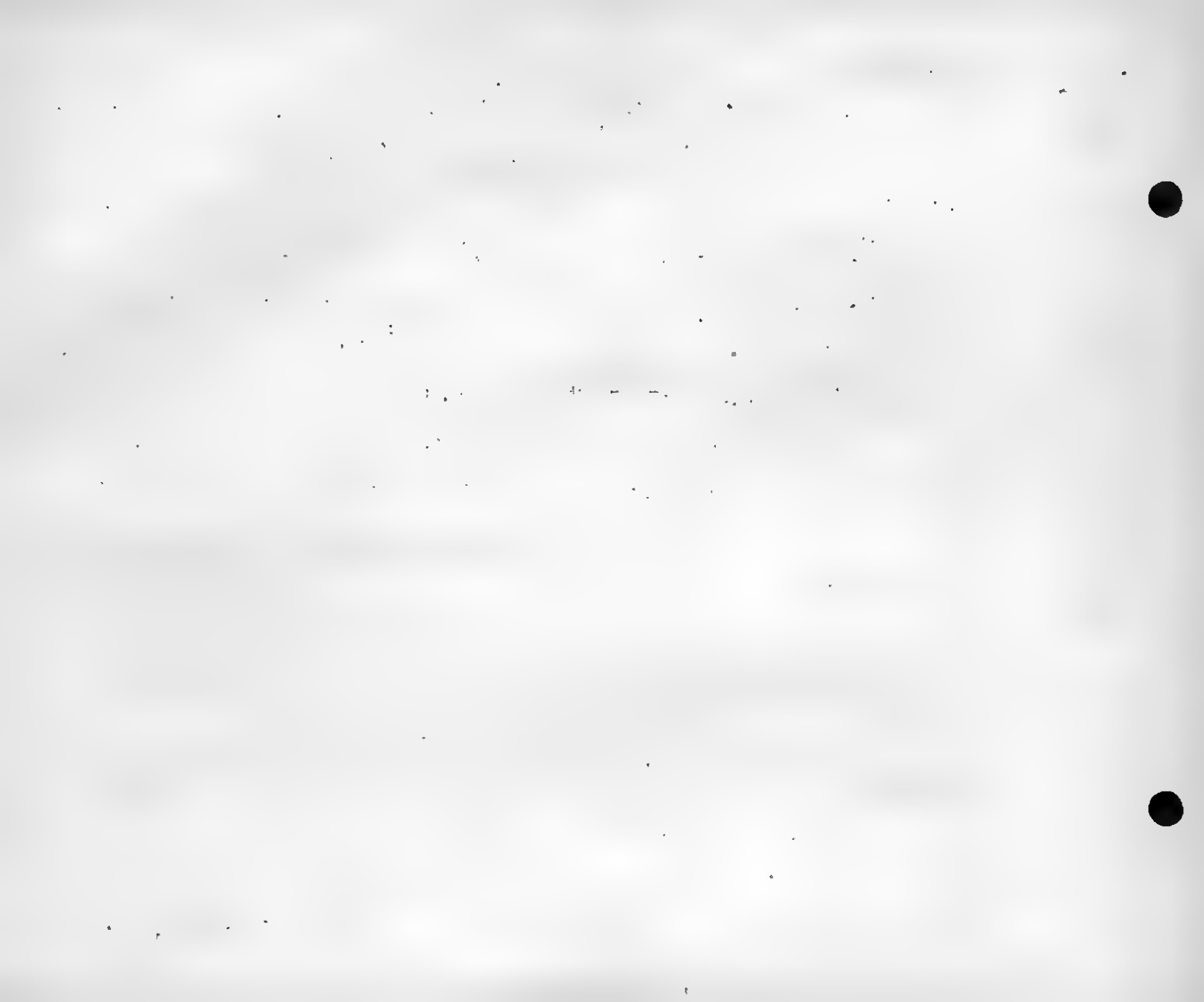
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|--|---|
| 04198 | | 04190 | |
| 1 DECEASED NAME
(Type or print) WILBUR Boyd Perne | | 2a. DATE OF DEATH
Month March Day 14 Year 1969 | |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH
December 19, 1893 | 6 AGE (In years last birthday)
75 YRS. |
| 7a BIRTHPLACE (State or foreign country)
Indiana | 7b CITIZEN OF WHAT COUNTRY?
U.S. America | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md. |
| 10 CITY OR TOWN OF DEATH
Takoma Park | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San. Hospital | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Radio Engineer | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Montgomery | 13b CITY OR TOWN
Rockville | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER
263 Congressional Lane #602 |
| 14. FATHER'S NAME First Horace Middle G. Last Perne | 15 MOTHER'S M.A.DEN NAME First Jennie Middle Jenner Last Jenner | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
Yes Navy WWI | |
| 16b SOCIAL SECURITY NO.
578-44-7743 | | 17 INFORMANT
Pt's chart | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) 4 weeks | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 weeks |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Partial Small Bowel Obstruction & Ulceration | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1965 , 19____, to March 14, 1969 , that (I) (we) last saw the deceased alive on March 13, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE
James M. Whitlock | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c DATE SIGNED |
| 22d. PHYSICIAN'S NAME (Type) James M. Whitlock | | 22e ADDRESS
7217 Carroll Ave Takoma Park Md | |
| 23a. BURIAL, CREMATION, BURIAL (Specify) | 23b DATE
3/18/69 | 23c NAME OF CEMETERY OR CREMATORY
Cedar Hill | 23d LOCATION (City or Town) (County) (State)
Prince George, Md. |
| 24. FUNERAL DIRECTOR
Tyson Wheeler | | 25a. REC'D BY REGISTRAR
DATE MAR 21 1969 | |
| ADDRESS
1331 Rockville Pike Rockville, Maryland | | 25b. REGISTRAR'S SIGNATURE
William J. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04199

CERTIFICATE OF DEATH

04191

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(Type or print) Herbert | | | First Middle Last | | | 2a. DATE OF DEATH
Month 3 Day 26 Year 69 | | | 2b. HOUR
7:00 PM | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
11/27/00 | | | 6. AGE (In years last birthday)
69 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
Russia | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery County Md. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Salesman | | | 12b. KIND OF BUSINESS OR INDUSTRY
Shoe Store | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Silver Spring | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER
10211 McKENNEY AVE. | | | 14. FATHER'S NAME
First KARL Middle Last PHILLIPS | | | 15. MOTHER'S MAIDEN NAME
First UNKNOWN Middle Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
NO | | | 16b. SOCIAL SECURITY NO
577-28-1306 | | | 17. INFORMANT
Mrs. Sally Phillips | | | Address
Same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b) Diffuse interstitial pulmonary fibrosis 6 months
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Myeloid Leukemia 10 years | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10 , 19 63 , to 3/26 , 19 69 , that (I) (we) last saw the deceased alive on 3/26 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M. W. Shapiro | | | | | | DEGREE
ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED
3/27/69 | | |
| 22d. PHYSICIAN'S NAME (Type)
M. W. SHAPIRO, M.D. | | | | | | 22e. ADDRESS
8107 EAST W. AVENUE SILVER SPRING, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
3-28-69 | | | 23c. NAME OF CEMETERY OR CREMATORY
NATIONAL MEMORIAL PARK | | | 23d. LOCATION (City or Town) (County) (State)
FALLS CHURCH VA | | |
| 24. FUNERAL DIRECTOR
GOODELL FUNERAL HOME 4217 9TH ST. N.W. | | | | | | 25a. REC'D BY REGISTRAR
DATE APR 1 1969 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

1

04200

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04192

| | | | | | |
|--|---|--|--|---|--|
| 1. DECEASED NAME
(Type or print) First Middle Last
Malissa Ann Phillips | | | 2a. DATE OF DEATH
Month Day Year
March 11 1969 | | 2b. HOUR
2:57 P M |
| 3 SEX
Female | 4 RACE
Caucasian | 5 DATE OF BIRTH
11 March 1969 | | 6 AGE (In years last birthday)
YRS MONTHS DAYS
— — 7 52 | IF UNDER 24 HRS
HOURS MIN
7 52 |
| 7a BIRTHPLACE (State or foreign country)
Virginia | 7b CITIZEN OF WHAT COUNTRY?
United States | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery Md | | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Naval Hospital | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
— | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Virginia | | 13b COUNTY
Prince William | | 13c CITY OR TOWN
Woodbridge | |
| 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
664 Bayvue Ave. Apt. 14 | | | |
| 14 FATHER'S NAME First Middle Last
Ronald L Phillips | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Karen Gunter | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service)
No | | 16b SOCIAL SECURITY NO
— | | 17 INFORMANT Address
Ronald L. Phillips 664 Bayvue Ave. Woodbridge Va. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis compatible with hyaline membrane disease
7701
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) —
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
— |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
— | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
— | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory)
OFFICE BUILDING, ETC | | 21f LOCATION Street or R.F.D. No City or Town County State
— — — — — | |
| 22a I certify that XX (this hospital) attended the deceased from 11 March 1969 , to 11 March 1969 , that XX (we) last saw the deceased alive on 11 March 1969 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above XX (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
Bernard Jay Bortz M.D. | | | | 22c DATE SIGNED
13 March 1969 | |
| 22d PHYSICIAN'S NAME (Type)
Bernard Jay BORTZ, M. D. | | | | 22e ADDRESS
Naval Hospital, Bethesda Maryland | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b DATE
3-17-69 | 23c NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery Arlington Va. | | 23d LOCATION (City or Town) (County) (State)
— — — | |
| 24 FUNERAL DIRECTOR
Robert A. Pumphrey Funeral Home | | ADDRESS
Bethesda Md. | | 25a DATE BY REGISTRAR
19 1969 | |
| VR AIS 141
45M 1/69 | | DATE
7557 Wisconsin | | 25b REGISTRAR'S SIGNATURE
— | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

71

2

BP

04201

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04193

| | | | | | | | | |
|--|--------------------|--|--|--|---|--|--|----------------------------------|
| 1 DECEASED NAME
(Type or Print) ADOLF HERMAN PLACK | | | 2a DATE KNOWN OF DEATH
Month 3 Day 30 Year 69 | | | 2b HOUR
8:45 AM | | |
| 3 SEX
M | 4 RACE
W | 5 DATE OF BIRTH
10-29-96 | 6 AGE (in years last birthday)
72 YRS. | IF UNDER YEAR
MONTHS
72 | IF UNDER 24 HRS
DAYS
72 | 2c DATE PRONOUNCED DEAD
Month 3 Day 30 Year 69 | | |
| 7a BIRTHPLACE (State or foreign country)
GERMANY | | 7b CITIZEN OF WHAT COUNTRY?
US | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Montgomery | | |
| 10 CITY OR TOWN OF DEATH
Takoma Park, Md. | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tel give street address)
Washington San & Hosp. | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Md. | | | 13b COUNTY
PR. GEO | 13c CITY OR TOWN
ADELPHI | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 3e STREET AND NUMBER
3100 Buck Lodge Rd. | | |
| 14 FATHER'S NAME
First PLACK Middle PLACK Last PLACK | | | 15. MOTHER'S MAIDEN NAME
First NET Middle AVAILABLE Last AVAILABLE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO | | | 16b SOCIAL SECURITY NO
(If yes give year or dates of service) | | | 17. INFORMANT
MRS HELENE J. PLACK ADDRESS | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY
4123 IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 2 a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Read | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
3/30/1969 | | |
| EXAMINER'S NAME (Type)
BELDEN R. READ M.D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | | 23b DATE
April 1, 1969 | | | 23c NAME OF CEMETERY OR CREMATORY
George Washington Cemetery | | |
| 24. FUNERAL DIRECTOR
Interma Funeral Home Inc J A Walters, 254 Carroll St Nfc | | | 23d LOCATION (City or Town) (County) (State)
Adelphi Pr Geo. Md | | | 25a REG'D BY REG STRAR
DATE APR 2 1969 | | |
| | | | 25b REG STRAR'S SIGNATURE
J Carlos J... | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 4, and 5, and 6, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 120, 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04202

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04194

| | | | | | | | | |
|--|--------|--|-----------------|--|---|--|---|--|
| 1. DECEASED NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | |
| LILA | | | MAY | INGRAM | POKORSKI | March | 22 | 1969 |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | White | | July 30, 1901 | | 67 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| West Virginia | | United States | | | | Montgomery County, Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Olney | | Montgomery General Hospital | | Analyst | | Government | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | Howard | | Highland | | | | P.O. Box 25 |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle Last |
| William | | | | Ingram | Charlotte | | A | Stevenson |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | |
| No. | | | | 236-32-1219 | | Richard G. Pokorski P.O. Box 25 Highland, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Atelectasis, Left lower lobe</u> | | | | | | | | 1 wk. |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary infection, Left lower lobe</u> | | | | | | | | 10 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of lung & metastasis</u> | | | | | | | | ? 3 mos. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes. | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1969, to Mar 22, 1969, that (I) (we) lost the deceased alive on 3-22-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Fredrick M. Norman M.D.</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-23-69 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS
Medical Center, Sandy Sp. Ind. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 3/27/69 | | Wildwood Cemetery | | Beckley, West Virginia | | |
| 24. FUNERAL DIRECTOR ADDRESS
Laurel Funeral Home Inc. of 550 Washington Blvd.
Howard M. Fleck | | | | 25a. REC'D BY REGISTRAR
DATE R 27 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. Jorgensen</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04203

04195

| | | | | | | | | | |
|---|--------|---|-----------------|---|---|---|--|--|-----------------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | |
| BERTHA | | K. | | PORTER | Month 3 Day 18 Year 69 | | | 405A.M. | |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS |
| F | W | | 10-23-1882 | | 86 YRS | | MONTHS DAYS | | HOURS MIN |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Maryland | | U. S. A. | | | | MONTGOMERY Md | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BETHESDA | | 5741 GROSVENOR LANE | | FACTORY WORKER | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | |
| MARYLAND | | MONT. | | SILVER SPRING | | | | 301 PIPING ROCK RD. | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | First Middle Last | | | | | | | |
| Theodore Koldewey | | Wilamena Faml | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | Address | | | |
| No | | 214-16-8718 | | WM R. PORTER (SON) | | BOX 359 LAUREL, MD. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerotic heart disease</u> (b) <u>chronic</u> (c) <u>chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3/19/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE <u>Janet A. Mocowitz, M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. DATE SIGNED | | | | | | | | | |
| | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Janet A. Mocowitz | | Bethesda, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3-20-69 | | Loudon Park Cemetery | | Baltimore City Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Howard H. Hubbard 4107 Wilkens Avenue 21229 | | | | | | MAR 20 1969 | | <u>Charles Judge</u> | |



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04204

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04196

| | | | | | | | | | | | | | | | | | |
|--|--|-----------------------------------|--|--|--|---|--|-----------------------------|--|---|--|-----------------------------|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | Month | | Day | | Year | | 2b. HOUR | |
| Edna | | Earl | | Posey | | | | 3 | | 21 | | 69 | | P | | P | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. COUNTY OF DEATH | | 8. MARRIED | | 9. COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | |
| F | | W | | 7-4-82 | | 86 | | Montgomery | | 12. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 13. STREET AND NUMBER | | 14. FATHER'S NAME | | 15. MOTHER'S M.A.D.E.N. NAME | |
| Virginia | | U S A | | 7-4-82 | | 86 | | Montgomery | | Housewife | | 7667-Maple Ave # 212 | | Edward J. Twiford | | Annie Millicent | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET AND NUMBER | | 14. FATHER'S NAME | | 15. MOTHER'S M.A.D.E.N. NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? | |
| Housewife | | At Home | | Maryland | | Montgomery | | YES | | 7667-Maple Ave # 212 | | Edward J. Twiford | | Annie Millicent | | NO | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 19. DATE OF OPERATION | | 20. AUTOPSY? | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
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| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | 22. TIME OF INJURY | | 23. HOW INJURY OCCURRED | | 24. I certify that (I) (the hospital) attended the deceased from | | 25. DATE SIGNED | |
| NO | | | | Myrtle Posey, Dau. As Above Item #13 | | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) | | 21. ACCIDENT WAS UNDERLYING | | | | | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04197

| | | | | | |
|---|-----------------|--|--|--|--|
| 1 DECEASED NAME
(Type or Print)
First Middle Last
DORIS J. POTTER | | | 2a DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year
3 15 1969 | | 2b HOUR
:35A |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
Aug. 25, 1896 | 6 AGE (in years last birthday)
72 YRS | IF UNDER 1 YEAR
MONTHS DAYS
HOJRS MIN | 2c DATE PRONOUNCED DEAD
Month Day Year
March 15 1969 |
| 7a BIRTHPLACE (State or foreign country)
Chicago, Illinois | | 7b CIT ZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md |
| 10 CITY OR TOWN OF DEATH
Kensington | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3121 Flyers Mill Rd | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
accountant | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE
Maryland | | 13b COUNTY
Montgomery | 13c CITY OR TOWN
Kensington | 3d HS DE CITY LIM TS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER
3121 Flyers Mill Road |
| 14. FATHER'S NAME First Middle Last
Taylor | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Margaret Young | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b SOCIAL SECURITY NO
(If yes give war or dates of service)
144-10-8814-A | | 17 INFORMANT ADDRESS
Joseph H. Potter 3121 Flyers Mill Rd. | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>due to barbiturate intoxication</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
- HOUR A.M. P.M. 3-15 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
Deceased, depressed, took an overdose of a barbiturate | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Home | | 21f. LOCATION Street or R.F.D. No City or Town County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
3/15/1969 | |
| EXAMINER'S NAME (Type)
BELOCN R. REAP M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b DATE
Mar 17, 1969 | | 23c NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | |
| 24 FUNERAL DIRECTOR
Shirley E. Fisher | | 25a MAR 19 1969 | | 25b REGISTRAR'S SIGNATURE | |
| 25c ADDRESS
316 E. Diamond Avenue Gaithersburg, Md. 20860 | | DATE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

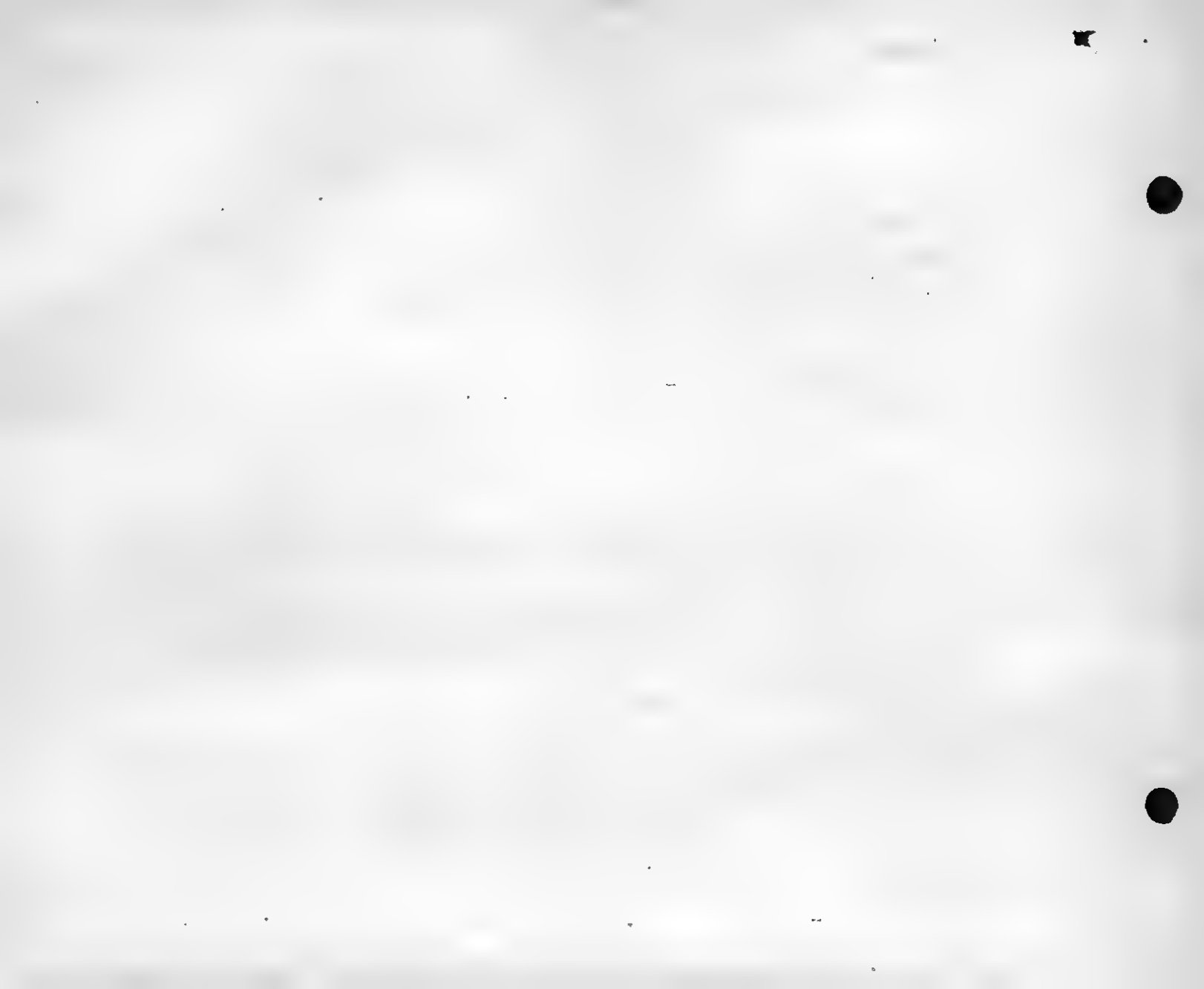
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04206

04198

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1 DECEASED-NAME
(Type or print) Ethel May Prince | | | 2a. DATE OF DEATH
Month March Day 15 Year 1969 | | | 2b. HOUR
4:45 P.M. | |
| 3 SEX
Female | | 4. RACE
white | | 5 DATE OF BIRTH
3-28-82 | | 6 AGE (In years last birthday)
86 YRS | |
| 7a BIRTHPLACE (State or foreign country)
Maine | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md | |
| 10 CITY OR TOWN OF DEATH
Tahoma Park | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington Sanitarium & Hospital | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Tahoma Park | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e STREET AND NUMBER
7208 Flower Avenue | | 14. FATHER'S NAME First Middle Last
Farwell | | 15 MOTHER'S MAIDEN NAME First Middle Last
? | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b SOCIAL SECURITY NO
577-38-0016T | | 17 INFORMANT
Records Washington Sanitarium & Hospital | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute enteric thrombosis - left leg
4444
DUE TO, OR AS A CONSEQUENCE OF (b) Shock
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) CNF
DUE TO, OR AS A CONSEQUENCE OF (c) CHF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day
Swiss
6-72 mol | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)
Office Building | | 21f. LOCATION Street or RFD No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug , 1968, to March 25 , 1969, that (I) (we) last saw the deceased alive on March 9 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
R. H. Sondstrom M.D. | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED
3/15/69 | |
| 22d PHYSICIAN'S NAME (Type)
R. H. Sondstrom M.D. | | | | 22e ADDRESS
7701 Carroll Ave Takoma Park, Md | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-19-69 | | 23c NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d LOCATION (City or Town) (County) (State)
Bladensburg, Maryland | |
| 24 FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | | | 25a REC'D BY REGISTRAR
MAR 24 1969 | | 25b REGISTRAR'S SIGNATURE
Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|--|---|--|-------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2c DATE OF DEATH | |
| JAMES | | E. | | QUEEN | | MARCH 11 | | 1969 | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 UNDECEASED YRS | |
| MALE | | WHITE | | 9/5/96 | | 72 | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| N. CAROLINA | | U.S.A. | | | | MONTGOMERY | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| BETHESDA | | SUBURBAN | | Builder | | Construction | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 3d INS DE CITY, TOWNSHIP? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| MARYLAND | | MONTGOMERY | | BETHESDA | | | | 9410 FERNWOOD ROAD | |
| 14 FATHER'S NAME | | First | | Middle | | Last | | 15 MOTHER'S MAIDEN NAME | |
| JOHN M | | QUEEN | | | | | | MARY ELLEN QUEEN | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | Address | |
| yes | | WW II | | 578-10-9842 | | NORMAN QUEEN - SON - 4674 ADAMS DRIVE SILVER SPRING | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>Rupture myocardium</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>myocardial infarction</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Thrombosis of coronary artery</u> | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21a INJURY OCCURRED | | 21b. PLACE OF INJURY | | 21c. LOCATION | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | (At home, farm, street, factory, office building, etc) | | Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 6, 1969</u> , to <u>date</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 10 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | |
| 22b SIGNATURE | | 22c. DATE SIGNED | | 22d PHYSICIAN'S NAME (Type) | | | | | |
| John G. Ball | | 11 March 1969 | | John G Ball | | | | | |
| 22d PHYSICIAN'S NAME (Type) | | 22e ADDRESS | | 22f. LOCATION | | | | | |
| | | 7936 Old Georgetown Rd Bethesda, Md | | Street or R.F.D. No City or Town County State | | | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3-14-69 | | Parklawn Cemetery | | Rockville Mont Md | | | |
| 24 FUNERAL DIRECTOR | | 24b ADDRESS | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| Robert A Pumphrey | | 7557 Wisconsin Ave Bethesda, Maryland | | MAR 14 1969 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Mayer | | | D. Rapoport | | | March 29 1969 | | 7:20 PM | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | Cau | | 2/19/96 | | 73 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Russia | | U.S.A. | | | | Montgomery Md. | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Silver Spring | | | Holy Cross | | | ret. merchant | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | 13b. COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | | Montgomery Maryland | | | Silver Spring | | 8201 16th St. | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| David Rapoport | | | Sara Guberman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b SOCIAL SECURITY NO. | | | 17 INFORMANT Address | | | |
| yes | | | WW I | | | May Rapoport 8201 16th St., SS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY. | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) <u>Coronary artery disease</u> | | | | | | | | | 3 yrs |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION | | Street or R.F.D. No | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/15/66</u> , 19 <u>66</u> , to <u>3/29/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/25/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | |
| <u>Bernard J. Walsh</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 3/29/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | |
| Bernard J. Walsh | | | | | | 1600 E. St. N.E. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 4/1/69 | | Adas Israel Cong. | | Wash., D.C. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Bernard Danzansky & Sons | | | | | | DATE APR 7 1969 | | <u>Charles Judge</u> | |
| 3501 14th St., N.W., Wash., D.C. | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|---|---|---|--|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 04209 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 04201 | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) Mary Elizabeth Reed | | | | | 2a. DATE OF DEATH
Month 13 Day 1969 | | | 2b. HOUR
3:45 P.M. | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
July 23 1903 | | 6. AGE (In years last birthday)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Woodfield | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rt. 2 Gaithersburg | | | 12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired.)
House wife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN
Woodfield | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Box 319 | |
| 14. FATHER'S NAME First Charles Middle Arnold Last | | | | | 15. MOTHER'S MAIDEN NAME First Emma Middle Gray Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Herman Reed Poolesville Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
180X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Metastases to osseum + lungs
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma of Cervix
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days
18 mos
3 1/2 years | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
arteriosclerotic heart disease - asthma | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
L.S. Batman MD DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-17-69 | | | |
| 22d. PHYSICIAN'S NAME (Type) Louisa S. Batman | | | | | 22e. ADDRESS
Damascus Md. | | | | | |
| 23a. BURIAL, CREMATION, REINTERMENT
Buried | | 23b. DATE
March 17 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Oak | | 23d. LOCATION (City or Town) (County) (State)
Gaithersburg Mont. Md. | | | | |
| 24. FUNERAL DIRECTOR Francis H. Barber ADDRESS Laytonsville Md. | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 19 1969 | | 25b. REGISTRAR'S SIGNATURE
William J. Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| Item 23 Film 410 3/26/69kk MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 04202 | |
|--|--|---|--|--|--|--|--|--|----------------------------------|---|--------------------|-------|--|
| Items 13 taken from birth certif. CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Baby Boy | | | | Middle REEDY | | Last | | 2a. DATE OF DEATH
3 Month 15 Day 69 Year | | | 2b. HOUR
3:47 M | | |
| 3 SEX
Male | | 4 RACE
White | | 5 DATE OF BIRTH
3-15-69 | | 6. AGE (In years last birthday)
YRS. — MONTHS — DAYS — HOURS — MINS — SECS — | | IF UNDER 1 YEAR
MONTHS — DAYS — HOURS — MINS — SECS — | | IF UNDER 24 HRS.
HOURS — MINS — SECS — | | | |
| 7a BIRTHPLACE (State or foreign country)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | Md | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Montgomery General | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Maryland | | 13b COUNTY
Montgomery | | 13c CITY OR TOWN
Poolesville | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER
Rt. 1, Box 67 | | | | | |
| 14 FATHER'S NAME First Middle Last
Carl Edward Roberts | | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Patricia Ilene Bentley | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or Unknown) no | | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT
Medical Records, MGH, Olney, Maryland | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Immature
777y DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE
Chester Wagstaff | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-17-69 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Chester Wagstaff, MD | | | | 22e ADDRESS
Medical Center, Sandy Spring, Md. | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
Removal | | 23b DATE
3/15/69 | | 23c NAME OF CEMETERY OR CREMATORY
Hunter Laboratory | | | | 23d LOCATION (City or Town) (County) (State)
915 19th St. N.W. Wash. D. C. | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR
DATE MAR 19 1969 | | 25b REGISTRAR'S SIGNATURE
J. C. ... | | | |



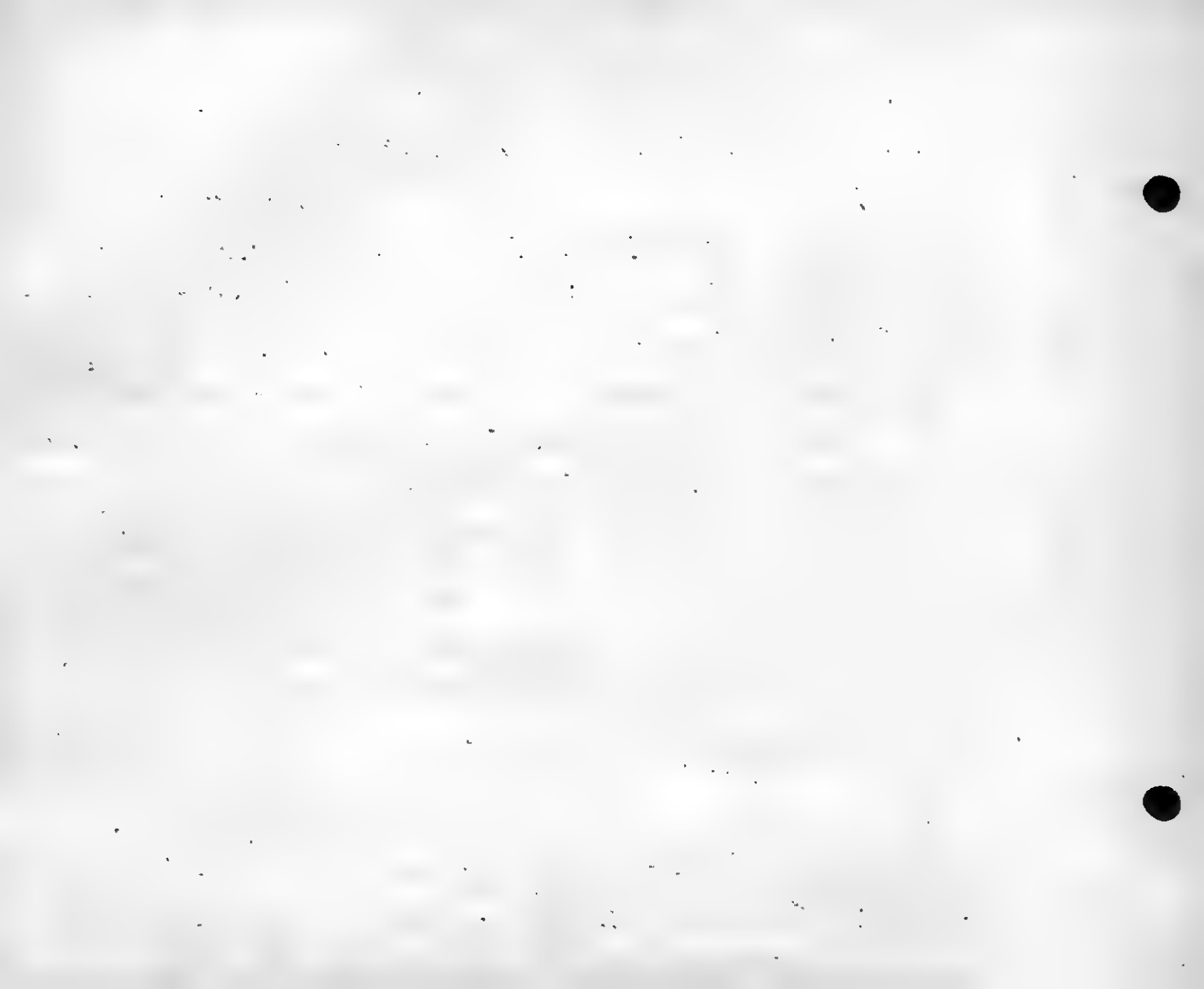
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
30M REV

Alfred C. Chambers

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|--|--|
| 04211 | | CERTIFICATE OF DEATH | | | | | | 04203 | | |
| 1. DECEASED-NAME
(Type or print) KATHERINE MACLEAN | | | First Middle Last REID. | | | 2a. DATE OF DEATH
Month Day Year MARCH 12 69 | | | 2b. HOUR
10³⁰ A | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Nov. 6, 1886 | | | 6. AGE (In years last birthday)
82 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS M.N. | |
| 7a. BIRTHPLACE (State or foreign country)
Capetown, Nova Scotia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
4804 Jasmine Drive | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife Ret. | | | 12b. KIND OF BUSINESS OR INDUSTRY
USA | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4804 Jasmine Drive | | |
| 14. FATHER'S NAME
First Middle Last
George MacLean | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mary MacDonald | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Mrs. Lillias R. Cobb | | Address 4804 Jasmine Drive Rockville, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardio-Respiratory arrest | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) myocardial infarction | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) Coronary Atherosclerosis | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1968 to March 1969 , that (I) (we) last saw the deceased alive on Feb 20 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Harold W. Draper M.D. | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
12 March 69. | | |
| 22d. PHYSICIAN'S NAME (Type)
HAROLD W. DRAPE M.D. | | | | | | 22e. ADDRESS
9801 Georgia Ave, Silver Spring, Md. | | | | |
| 23a. BURIAL-CREATION
REMOVAL (Specify)
Interment | | 23b. DATE
March 13, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery, Bladensburg, Md. | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Md. | | | | |
| 24. FUNERAL DIRECTOR
W. W. Chambers Co | | | | ADDRESS
8455 Ga Ave Silver Spring, Md. | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |
| | | | | DATE
MAR 20 1969 | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04212

CERTIFICATE OF DEATH

04204

| | | | | | | | | | |
|--|--|--|---|--|---|--|---|---|---|
| 1 DECEASED NAME
(Type or print) <i>George I. Lyman</i> | | | 2a. DATE OF DEATH
Month <i>March</i> Day <i>9</i> Year <i>69</i> | | | 2b. HOUR
<i>3:30 PM</i> | | | |
| 3 SEX
<i>M.</i> | | 4 RACE
<i>White</i> | | 5 DATE OF BIRTH
<i>2/23/01</i> | | 6 AGE (in years last birthday)
<i>68</i> YRS | | 7 UNDER 1 YEAR
MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN <i>0</i> | |
| 7a BIRTHPLACE (State or foreign country)
<i>Minn.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
<i>Montgomery</i> | | | |
| 10 CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>Personnel Director</i> | | | 12b NO. OF BUSINESS OR INDUSTRY | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i> | | 13b COUNTY
<i>Montgomery</i> | | 13c CITY OR TOWN
<i>Rockville</i> | | 13d NO. OF CITY LOTS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
<i>615 Blossom Drive</i> | |
| 14 FATHER'S NAME
First <i>George</i> Middle <i>Reynolds</i> Last <i>Lyman</i> | | | 15 MOTHER'S MAIDEN NAME
First <i>Josephine</i> Middle <i>Northampton</i> Last <i>Lyman</i> | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>YES</i> | | 16b SOCIAL SECURITY NO.
(If res gave war or defense service)
<i>WW II</i> | | 17 INFORMANT
<i>Wife</i> | | 18 ADDRESS
<i>Same</i> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET OF DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Exsanguination</i> | | | | | | | | | <i>8 hrs.</i> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Large Gastric Ulcer - Perforated</i> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION
<i>3/9/68</i> | | 19b CONDIT.ON FOR WHICH OPERATION WAS PERFORMED
<i>Mammary Gland</i> | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>3/9/69</i> to <i>3/9/69</i> , that (I) (we) last saw the deceased alive on <i>3/9/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE
<i>Richard C. Myers</i> | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED
<i>3/9/69</i> | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Richard C. Myers</i> | | | | | 22e. ADDRESS
<i>8512 Old Georgetown Road Bethesda, Maryland</i> | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE
<i>3-12-69</i> | | 23c NAME OF CEMETERY OR CREMATORY
<i>Rockville Cemetery</i> | | 23d LOCATION (City or Town) (County) (State)
<i>Rockville Maryland</i> | | | |
| 24 FUNERAL DIRECTOR
<i>Robert A Pumphrey</i> | | | | | ADDRESS
<i>7557 Wisc. Ave Beth Md</i> | | 25a REG. DIR. REGISTRAR
DATE <i>MAR 14 1969</i> | | 25b REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR |
|--|--|---|--|---|-------------------------------------|--|--|
| AZOR JACKSON RHEA | | | | | MARCH 14, 1969 | | 4:05 PM |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | |
| MALE | CAUCASIAN | | 11 JANUARY 1903 | | 66 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| ALABAMA | USA | | | MONTGOMERY Md | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BETHESDA | NAVAL HOSPITAL BETHESDA | | U.S. MARINE CORPS | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | | |
| N.C. | Carteret | BEAUFORT | | 1537 Ann Street | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First Middle Last |
| William Sampson Rhea | | | | | (Unknown) | | Herring |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or years of service)
Yes or unknown | | 16b. SOCIAL SECURITY NO | 17. INFORMANT | | | | |
| 1951-1953 | | 237-54-1148 | Annie Rhea-wife Address
1537 Ann St., Beaufort, N.C. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Abdominal Aortic Aneurysm</u>
4 +
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Massive Retroperitoneal Hemorrhage</u>
(c) <u>Secondary resection of Abd. Aortic Aneurysm</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (s) (this hospital) attended the deceased from <u>26 FEB</u> , 19 <u>69</u> , to <u>14 MAR</u> , 19 <u>69</u> , that (s) (we) last saw the deceased alive on <u>14 MARCH</u> , 19 <u>69</u> , and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>W.E. Beasley III M.D.</u> | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-15-69 | |
| 22d. PHYSICIAN'S NAME (Type) | | W.E. Beasley III, M.D. | | 22e. ADDRESS
Naval Hospital, Bethesda, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | 3-19-69 | Elmwood Cemetery | | Birmingham, Alabama. | | | |
| 24. FUNERAL DIRECTOR | | R.A. Pumphrey for ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Johns Ridout, 2116 S. 8th St., Birmingham, Ala. | | | | MAR 20 1969 | | <u>Charles Judge</u> | |

**FOR STATE
HEALTH DEPT.**

04214

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04206

| | | | | | | | | | | | | | |
|---|--------|--|--|--|-------------------------------|---|------------------------------|---|---|---|------------------------------|--|--|
| 1 DECEASED NAME
(Type or Print) | | First | | Middle | | Last | | 2a DATE KNOWN
OF DEATH | | ESTIMATED
Month Day Year | | 2b HOUR
8 ⁵⁵ M | |
| PERLA | | COLBY | | RIDGATE | | | | 3-18 | | 1969 | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE
(in years
last birthday) | 7 UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | | 2c DATE PRONOUNCED DEAD
Month Day Year | | 2d HOUR
9 ⁵⁵ M | | |
| Female | Cauc. | Mar. 14, 1889 | | 80 YRS | | | | | March 18 | | 1969 | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Penn | | USA | | | | Montgomery | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Kensington | | Carroll Hall Nursing Home | | Housewife | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | | | | | |
| D. C. | | -- | | Washington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1225 L St., N. W. | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle Last | |
| Unknown | | | | | | | | Unknown | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | | | | | | | |
| No | | Unknown | | Walter Gilcrest (Atty) | | 1317 F. St. N. W. WashDC | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> | | | | | | | | | | | | Sudden | |
| 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio Vascular Disease</u> | | | | | | | | | | | | years. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| | | HOUR A.M. P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (Type) | | JOHN G. BALL | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b DATE SIGNED | |
| | | | | | | | | | | | | March 19, 1969 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) | | | |
| Burial | | 3025-69 | | Arlington National | | Arlington | | Virginia | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a REC'D BY REGISTRAR | | | | 25b REGISTRAR'S SIGNATURE | | | | | |
| Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md | | | | APR 1 1969 | | | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | |
| INFANT | | | MALE | | | RIGGS | | | MARCH 15 1969 11:58 PM | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | |
| MALE | | | NEGRO | | | 3/15/69 | | | 17 YRS | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| BETHESDA MD | | | U. S. A. | | | | | | MONTGOMERY Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BETHESDA | | | SUBURBAN | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| MARYLAND | | | MONTGOMERY | | | CATHESDA | | | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S M A D E N NAME First Middle Last | | | | | | | | |
| | | | E. S. E | | | RIGGS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anoxia</u> | | | | | | | | | | | |
| 7769 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Immaturity</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Premature labor</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) | | | | | |
| | | | | | | | | | | | |
| 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | 3/16/69 | | |
| | | | | | | | | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| | | | 3/18/69 | | | Suburban Hospital | | | Bethesda - Montg. - Md. | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Mrs. Amelia C. Carter | | | Amixichoto | | | MAR 24 1969 | | | J. C. Anles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415
30M REV 11/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04216

CERTIFICATE OF DEATH

04208

| | | | | | | | | | |
|---|--|---|--|---|--|---|---|---|--|
| 1. DECEASED-NAME
(Type or print)
Charles Paunelle Roane Jr. | | | 2a. DATE OF DEATH
Month Day Year
March 25 1969 | | | 2b. HOUR
7:30 M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
29 September 1952 | | 6. AGE (In years last birthday)
16 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Washington, DC | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
The Clinical Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
8620 Hempstead Avenue | |
| 14. FATHER'S NAME
Charles Paunelle Roane Sr. | | | 15. MOTHER'S MAIDEN NAME
Dale Hedrick | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT The Medical Records Address
The Clinical Center, NIH, Bethesda, Md. 20014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia, probable staphylococcal</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Septicemia with shock</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Acute lymphocytic leukemia</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 days
3 days
1 month | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY)
OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that IX (this hospital) attended the deceased from <u>11 March</u> , 19 <u>69</u> , to <u>25 March</u> , 19 <u>69</u> , that IX (we) last saw the deceased alive on <u>25 March</u> , 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, IX (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Richard J. Samaha MD</u> | | | | 22c. DATE SIGNED
25 March 1969 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Richard J. Samaha | | | | 22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-28-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Denton Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Denton, Caroline County, Md. | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave.
N.W., Wash., D.C., 20016 | | | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>W. Samaha, Registrar</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

1
Cleared by Dr. Peab.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04217

CERTIFICATE OF DEATH

04209

| | | | | | | | |
|--|--|---|---|---|--|---|---|
| 1. DECEASED NAME
(Type or print) <u>Claudia S. Robertson</u> | | | 2a. DATE OF DEATH
Month <u>3</u> Day <u>23</u> Year <u>69</u> | | | 2b. HOUR
<u>11:10</u> AM | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>W.H.</u> | | 5. DATE OF BIRTH
<u>1-7-86</u> | | 6. AGE (In years last birthday)
<u>83</u> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<u>md</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>US</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>montgomery</u> Md | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>Holy Cross</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<u>Self Employed</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>md.</u> | | 13b. COUNTY
<u>montgomery</u> | | 13c. CITY OR TOWN
<u>Silver Spring</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<u>10710 Huntley Ave.</u> | | | | | | | |
| 14. FATHER'S NAME
First <u>Samuel L.</u> Middle <u>Robertson</u> Last | | | 15. MOTHER'S MAIDEN NAME
First <u>Alice A.</u> Middle <u>Ricketts</u> Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <u>No</u> | | 16b. SOCIAL SECURITY NO
<u>213-48-1323</u> | | 17. INFORMANT
<u>Cooke A. Robertson-10710 Huntley Ave.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>887X</u> IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>9 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Arteriosclerotic heart disease - Broncho pneumonia</u> | | | | | | | |
| 19a. DATE OF OPERATION
<u>3-19-69</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Fracture R. hip</u> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. _____ P.M. <u>3-19-1969</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)
<u>Fall at home</u> | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
<u>Home</u> | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____
<u>10710 Huntley Ave Mont. Md</u> | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 19</u> , 19 <u>69</u> , to <u>Mar 23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 21/19 69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Roland J. Cavanaugh</u> | | | | 22c. DATE SIGNED
<u>March 24</u> | | 22d. PHYSICIAN'S NAME (Type)
<u>Roland J. Cavanaugh</u> | |
| 22e. ADDRESS
<u>1015 Spring St., Silver Spring, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>3/27/69</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rockville</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Rockville, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u>
<u>Rockville, Md.</u> | | | | 25a. REC'D BY REGISTRAR
<u>MAR 26 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>William J. Dardas</u> | |



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04218
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

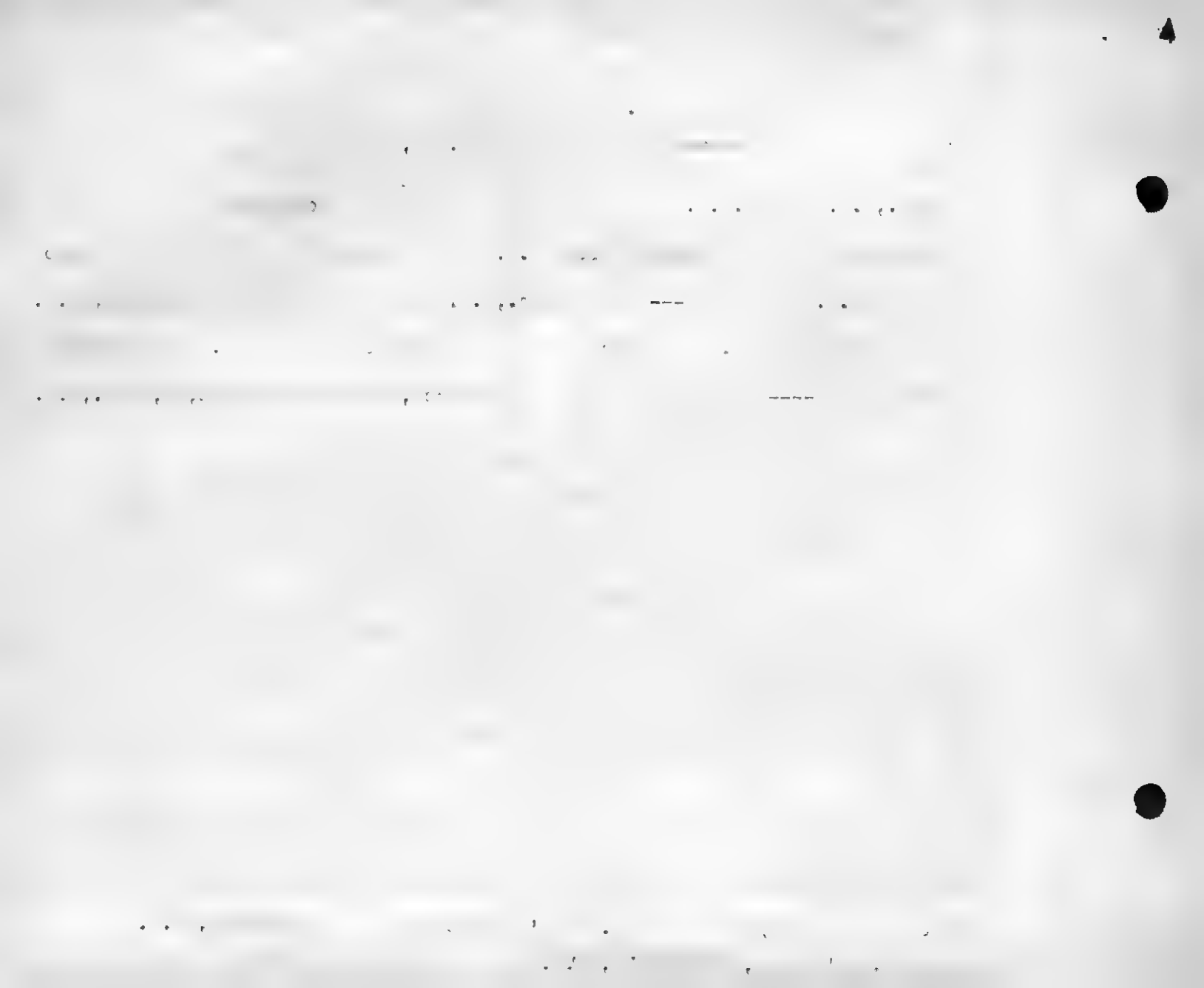
04210

| | | | | | |
|--|-------------------------------------|--|--|--|--|
| 1. DECEASED-NAME
(Type or print)
First Middle Last
William Orem Robinson | | | 2a. DATE OF DEATH
Month Day Year
March 21 1969 | | 2b. HOUR AM
12:59 |
| 3 SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
8 November 1959 | | 6 AGE (In years
lost birthday)
9 YRS. | 7 UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (State or foreign
country)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery | | Md |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
The Clinical Center | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
None | 12b. KIND OF BUSINESS OR
INDUSTRY |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before
admission) STATE
Maryland | | 13b. COUNTY
Montgomery | 13c CITY OR TOWN
Silver Spring | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
10215 Woodmoor Circle |
| 14 FATHER'S NAME
First Middle Last
Thomas G. Robinson | | 15 MOTHER'S MAIDEN NAME
First Middle Last
Virginia Gardner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO
(If yes give war or dates of service)
None | | 17. INFORMANT The Medical Records Address
The Clinical Center, NIH, Bethesda, Md. 20014 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a) {
stating the underlying cause
last. (b) Leukemia - lymphosarcoma
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
30 minutes
10 months |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (X) (this hospital) attended the deceased from 18 March, 19 69, to 21 March, 19 69, that (X) (we) lost
saw the deceased alive on 21 March 1969, and that in (X) (our) opinion death occurred on the date and hour and from the
causes stated above, (X) (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE
Alan L. Snyder | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
21 March 1969 | |
| 22d. PHYSICIAN'S
NAME (Type)
Alan L. Snyder, M.D. | | 22e ADDRESS The Clinical Center, National
Institutes of Health, Bethesda, Md. 20014 | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
3-25-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | |
| 24. FUNERAL DIRECTOR
Francis J. Collins | | 400 University Blvd. W.
Silver Spring, Md. | | 25a. REC'D BY REGISTRAR
MAR 27 1969
DATE | |
| 25b. REGISTRAR'S SIGNATURE
Francis J. Collins | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) Eugene | | | First L. Middle Rocca | | | 2a. DATE OF DEATH Month MARCH Day 23 Year 1969 | | | 2b. HOUR 3:19A M | | |
| 3 SEX Male | | | 4 RACE Caucasian | | | 5 DATE OF BIRTH Jan. 29, 1902 | | | 6 AGE (in years last birthday) 67 YRS | | |
| 7a BIRTHPLACE (State or foreign country) Wash., D.C. | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH Montgomery Md | | |
| 10 CITY OR TOWN OF DEATH Rockville | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Potomac Valley N.H. | | | 12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Retired | | | 12b KIND OF BUSINESS OR INDUSTRY Auto | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE D.C. | | | 13b COUNTY --- | | | 13c CITY OR TOWN Wash., D.C. | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e STREET AND NUMBER 4224 Military Road, N.W. | | | 14 FATHER'S NAME First John Middle B. Last Rocca | | | 15 MOTHER'S MAIDEN NAME First Assunta Middle L. Last Casassa | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO. 579-60-88117 | | | 17. INFORMANT Address Ray Rocca, 3350 Tennyson St, NW, Wash., D.C. | | | | | |
| 18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis, Metastatic
175 x DUE TO, OR AS A CONSEQUENCE OF (b) Prostatic Carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 4 yrs
6 yrs + | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18) | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Feb 1963 to Mar 23, 1969 , that (I) (we) last saw the deceased alive on Mar 20, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Michel M. Healy, MD | | | 22c. PHYSICIAN'S NAME (Type) Michel M. HEALY, MD | | | 22d. ADDRESS 5411 W. Cedar La., Bethesda, Md | | | 22e. DATE SIGNED 3/23/69 | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | | | 23b. DATE 3/26/69 | | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Washington, D.C. | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C. | | | 25a. REC'D BY REGISTRAR MAR 26 1969 | | | 25b. REGISTRAR'S SIGNATURE Charles Jones | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
04220
CERTIFICATE OF DEATH

04212

| | | | | | | | | |
|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
MARK ALAN ROLAND | | | 2a. DATE OF DEATH
Month Day Year
MARCH 25 1969 | | | 2b. HOUR
9 ⁰⁰ AM | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MARCH 25, 1969 | | 6. AGE (In years last birthday)
— YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery County Md. | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Md. | | | 13b. COUNTY
P. G. | | 13c. CITY OR TOWN
Bowie | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
12813 Beechtree Lane | | | 14. FATHER'S NAME First Middle Last
Daniel Patrick Roland | | | | | |
| 15. MOTHER'S MAIDEN NAME First Middle Last
Rebecca NMN Bryant | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO | | | | | |
| 16b. SOCIAL SECURITY NO
NINE | | | 17. INFORMANT
FATHER DANIEL P. ROLAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity, severe. (1 lb, 12 ozs) 3 hrs 25 min
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour AM Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 25, 1969, to MARCH 25, 1969, that (I) (we) last saw the deceased alive on MARCH 25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
H. N. Kwok M.D. DEGREE | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
3/25/69 | |
| 22d. PHYSICIAN'S NAME (Type)
Robert Kwok M.D. | | | | | 22e. ADDRESS
Holy Cross Hosp. Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
MARCH 27, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
M.T. Olive Tree | | 23d. LOCATION (City or Town) (County) (State)
WASHINGTON D.C. | | |
| 24. FUNERAL DIRECTOR
LANHAM FUNERAL HOME
of Robert G. Beall | | | | | ADDRESS
LANHAM, MD. | | 25a. REC'D BY REGISTRAR
DATE
MAR 27 1969 | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 04221 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04213 | |
| Item 6 Film 410 3/18/69 kk | | | | | | | |
| 1 DECEASED-NAME (Type or print)
First <u>Jessie</u> Middle <u>James</u> Last <u>Roper</u> | | | | 2a. DATE OF DEATH
Month <u>March</u> Day <u>0</u> Year <u>69</u> | | 2b. HOUR
<u>7:45</u> M | |
| 3. SEX
<u>M</u> | | 4 RACE
<u>Negro</u> | | 5. DATE OF BIRTH
<u>4-17-1896</u> | | 6 AGE (in years lost birthday)
<u>72</u> YRS | |
| 7a BIRTHPLACE (State or foreign country)
<u>South Carolina</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
<u>Mont.</u> | |
| 10. CITY OR TOWN OF DEATH
<u>Kensington Md.</u> | | 11 NAME OF HOSPITAL OR INSTITUTION (if in hospital give street address)
<u>3000 Macomas Ave.</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<u>Tailor</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE
<u>D.C.</u> | | 13b. COUNTY
<u>Washington</u> | | 13c. CITY OR TOWN
<u>Washington</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
<u>1412 Quincy St. N.W.</u> | | 14 FATHER'S NAME First <u>Daniel</u> Middle <u>Povicha</u> Last <u>UNKNOWN</u> | | 15 MOTHER'S MAIDEN NAME First <u>UNKNOWN</u> Middle <u>UNKNOWN</u> Last <u>UNKNOWN</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (if yes give war or dates of service) <u>W. W. I.</u> | | 16b. SOCIAL SECURITY NO
<u>446-04-1796</u> | | 17 INFORMANT
<u>JOHN ROPER-6231 N.D. AVE, D.C.</u> | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> | | | | | | | |
| 2119 DUE TO, OR AS A CONSEQUENCE OF <u>Anemia</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cystitis</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 wks</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Alcoholic & senile dementia</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 <u>69</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/26</u> , 19 <u>69</u> , to <u>3/10</u> , 19 <u>69</u> , that (we) saw the deceased alive on <u>3/10</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Marvin Wadler M.D.</u> | | | | 22c. DATE SIGNED <u>3/10/69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u> | | | | 22e. ADDRESS <u>8218 Wisconsin Ave. Beth. Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>3-13-69</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKES CHURCH MONCK'S CORNER, S.C.</u> | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <u>Frazier Funeral Home 389 R.I.A.</u> | | | | 25a. REC'D BY REGISTRAR <u>MAR 14 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|---|---|--|--------------------------------------|----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | Fst M dle Lost | | | 2a. DATE OF DEATH
Month Day Year | | | 2b HOUR |
| ANNE EVA. ROSENFELD | | | | | | MARCH 22 1969 | | | 3 15 P M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER YEAR MONTHS DAYS HOURS M.N. | |
| FEMALE | | CAUCASIAN | | JULY 10, 1915 | | 53 YRS. | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| D.C. | | U.S.A. | | | | MONTGOMERY Md | | | |
| 1d. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY |
| SILVER SPRING | | | HOLY CROSS HOSPITAL | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER |
| MARYLAND | | | MONTGOMERY | | SILVER SPRING | | YES | | 8510 16 STREET APT 714 |
| 14 FATHER'S NAME First Middle Last | | | 5 MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| SAMUEL ALLDY | | | SARAH KATZ | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | Address | | |
| | | | | | EUGENE ROSENFELD | | 8510-16 th ST, #714 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DISSEMINATED CARCINOMA OF BREAST | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) 6 years | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| Steroid-induced diabetes mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES | | NO | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1969, to 3-22-1969, that (I) (we) last saw the deceased alive on 3-21-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| JASON GEIGER, M.D. | | | | | | | 3-23-69 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e ADDRESS | | 22f. REGISTRAR'S SIGNATURE | | | | |
| JASON GEIGER, M.D. | | | 800 PERSHING DRIVE SILVER SPRING, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | Mar. 24, 1969 | | King David Memorial Garden | | Falls Church VA. | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | 25a REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Donald M. Stein | | | 232 Carroll | | MAR 26 1969 | | Hebrew Memorial Funeral Home St., N.W. Wash., D.C. | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 04223 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04215 | |
|---|--|---|---|---|---------|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | |
| CORA | | | M. | | ROSEWAG | 3 10 69 | |
| 3. SEX
F | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
7-4-'78 | | 6. AGE (In years last birthday)
90 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address)
Grosvenor Lane Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Cath. Co | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) STATE
District of Columbia | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1228 EYE ST. N.W. | |
| 14. FATHER'S NAME
First Middle Last
George M. Walker | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Bertha Leonhardt | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service) | | 16b. SOCIAL SECURITY NO.
578-46-4598 | | 17. INFORMANT
Address
Ellenora F. Walker-1228 Eye St. N.W. | | | |
| 18. CAUSE OF DEATH (Enter on 1 line one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>chronic</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>aortic valvular stenosis</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> , 19 <u>69</u> , to <u>3/9</u> , 19 <u>69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>3/9</u> , 19 <u>69</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>David A. Howard, M.D.</u> | | | | 22c. DATE SIGNED
3/10/69 | | 22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3.12.69 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington D.C. | |
| 24. FUNERAL DIRECTOR
ADDRESS
Lee Funeral Home 300 4th St N E Wash | | | | 25a. REC'D BY REGISTRAR
MAR 11 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS
45M

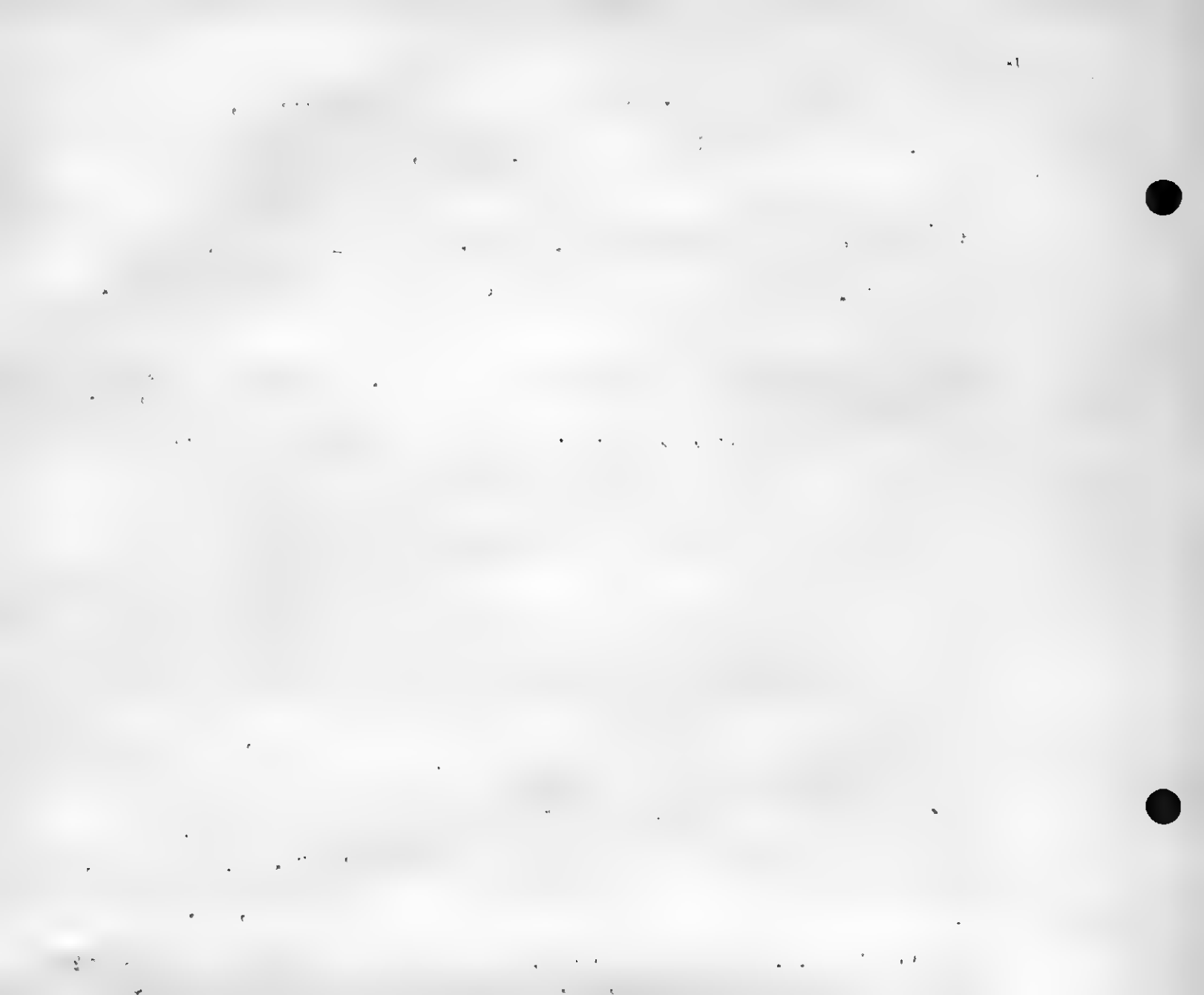
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 042224 | | | | | | | | | | | |
| 04216 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a DATE OF DEATH
Month Day Year | | | 2b HOUR
30 | | |
| JULIA W. ROWE | | | | | | MARCH 12 1969 | | | 1230 | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | | |
| FEMALE | | | WHITE | | | DEC 17, 1918 | | | 50 YRS | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | |
| SCOTLAND | | | USA | | | | | | Montgomery | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USJA: OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | Suburban | | | Teacher of Nursing | | | Nursing | | |
| 13a USUAL RESIDENCE (Where deceased lived 6 months or more) STATE | | | 13b CITY OR TOWN | | | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d STREET AND NUMBER | | |
| DC. | | | Washington | | | YES | | | 4817 36th St. N.W. 201 | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Alfred Louis Rowe | | | Joan Dolymple | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | Address | | |
| No | | | Unknown | | | Louis Rowe | | | 1100 Hunt Club Drive Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RENAL FAILURE - UREMIA | | | | | | | | | | 4-6 mo. | |
| DUE TO, OR AS A CONSEQUENCE OF (b) SYSTEMIC LUPUS ERYTHEMATOSUS | | | | | | | | | | 10 yrs | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | | |
| BRONCHOPNEUMONIA AND CONGESTIVE HEART FAILURE | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| None | | | NA | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | |
| | | | NA | | | NA | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f LOCATION | | | City or Town County State | | |
| | | | NA | | | NA | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from Feb 7, 1969, to Feb 12, 1969, that (I) (we) saw the deceased alive on Feb 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | DEGREE | | | 22c DATE SIGNED | | |
| Howard Levine, M.D. | | | | | | | | | 3-12-69 | | |
| 22d PHYSICIAN'S NAME (Type) | | | | | | 22e ADDRESS | | | | | |
| HOWARD LEVINE | | | | | | 8218 Wisconsin Ave, Bethesda, Md. | | | | | |
| 23a BURIAL, CREMATION, or other disposition | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | |
| Burial | | | 3-14-69 | | | Cedar Hill Cemetery | | | Suitland Pr. Geo Md | | |
| 24 FUNERAL DIRECTOR | | | | | | 25a REC'D BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | |
| Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md | | | | | | MAR 14 1969 | | | 1171 Lincoln Under | | |

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME
(Type or print)
Frederick Joseph Roy | | 2a. DATE OF DEATH
Month 3 Day 11 Year 69 | | 2b. HOUR
3:05 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
2/24/95 | |
| 6. AGE (In years last birthday)
74 | | 7. BIRTHPLACE (State or foreign country)
Wells River Vermont | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Montgomery County | | 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Accountant | | 12b. KIND OF BUSINESS OR INDUSTRY
Government | | 13a. STREET AND NUMBER
13401 Clifton Dr. SSMD. | |
| 13b. CITY OR TOWN
Montgomery | | 13c. CITY OR TOWN
Sil. S rg. | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14. FATHER'S NAME First Ovide Middle Roy Last Roy | | 15. MOTHER'S MAIDEN NAME First Mary Middle Picard Last Picard | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) yes | |
| 16b. SOCIAL SECURITY NO.
218 38 9659 | | 17. INFORMANT
wife Margaret | | 18. ADDRESS
13401 Clifton Dr. SSMD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF, (b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF, (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY
HOUR A.M. 19 P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1952 to 11 March 1969 , that (I) (we) last saw the deceased alive on 2 March 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | |
| 22b. SIGNATURE
William D. Aud, M.D. | | | | 22c. DATE SIGNED
3/11/69 | |
| 22d. PHYSICIAN'S NAME (Type)
William D. Aud, M.D. | | 22e. ADDRESS
9006 Colesville Rd., Silver Spring, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-15-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | |
| 23d. LOCATION (City or Town)
Silver Spring, Md | | 23e. LOCATION (County) (State)
 | | | |
| 24. FUNERAL DIRECTOR
James H. Hedges | | 24a. REC'D BY REGISTRAR
MAR 17 1969 | | 24b. REGISTRAR'S SIGNATURE
James H. Hedges | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|--|--|--|-----------------------------------|--|-------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 04226 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) David J. Rudolph | | | | | | 2a. DATE OF DEATH March 31, 1969 | | | 2b. HOUR M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH August 1, 1908 | | 6. AGE (In years last birthday) 60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery | | | Md | | |
| 10. CITY OR TOWN OF DEATH Tokoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Guard-Security-Vitro | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | 13b. COUNTY Montg | | 13c. CITY OR TOWN Rockville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 4318 Aspin Hill Rd. | |
| 14. FATHER'S NAME First John Middle Rudolph Last Rudolph | | | | 15. MOTHER'S MAIDEN NAME First Lydia Middle Pifer Last Pifer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give year or dates of service) No | | | | 16b. SOCIAL SECURITY NO. 191-03-6749 | | 17. INFORMANT Richard J. Rudolph Address 4318 Aspin Hill Road Rockville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1621 (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 30 , 19 68 , to March 31 , 19 69 , that (I) (we) lost saw the deceased alive on March 31 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Lewis Dennis | | | | 22c. DATE SIGNED 4/1/69 | | 22d. PHYSICIAN'S NAME (Type) Lewis Dennis | | 22e. ADDRESS 3906 Bel Pre Rd. Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, BURIAL (Specify) | | 23b. DATE 4/4/69 | | 23c. NAME OF CEMETERY OR CREMATORY Lloyd Cemetery | | 23d. LOCATION (City or Town) (County) (State) Ebensburg, Pa. | | | | | |
| 24. FUNERAL DIRECTOR Tyson Wheeler F.H. ADDRESS 1331 Rockville Pike Rockville, Md. | | | | | | 25a. REC'D BY REGISTRAR APR 7 1969 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04227

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04219

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(Type or print) First Middle Last
EMMA Delores Ruscher | | | 2a. DATE OF DEATH
Month Day Year
MARCH 7 1969 | | 2b. HOUR
2:15 PM |
| 3. SEX
FEMALE | 4. RACE
CAUC. | 5. DATE OF BIRTH
FEB. 15, 1888 | | 6. AGE (In years last birthday)
81 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
U.S.A. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GREYLOCK LANE Nursing Home | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)
Reg. Nurse | 12b. KIND OF BUSINESS OR INDUSTRY
Nursing | |
| 13a. USUA. RESIDENCE (Where deceased lived, if institution Resident before admission) STATE
md. | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
1007 University Blvd. | |
| 14. FATHER'S NAME First Middle Last | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO
220-54-9828 | 17. INFORMANT Address
Nursing Home records | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Septicemia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) cardiovascular insufficiency | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days
5 days
chronic |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. LOCATION Street or R.F.D. No City or Town County State | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not white <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) | | 21f. LOCATION Street or R.F.D. No City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11/69 to 3/1/69 , that (I) (we) last saw the deceased alive on 3/1/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | |
| 22b. SIGNATURE
David Morowitz M.D. | | 22c. ADDRESS
9237 Three Oaks Drive, Silver Spring Maryland | | 22d. DATE SIGNED
3/1/69 | |
| 22d. PHYSICIAN'S NAME (Type)
David Morowitz | | 22e. ADDRESS
9237 Three Oaks Drive, Silver Spring Maryland | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify)
Burial | | 23b. DATE
3/5/69 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Prince George Co. Md. |
| 24. FUNERAL DIRECTOR
Tyson Wheeler | | ADDRESS
1331 Rock Pike Rockville, Md. | | 25a. REC'D BY REGISTRAR
MAR 11 1969 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

FOR STATE
HEALTH DEPT.

04228

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04220

| | | | | | | | | |
|---|---------|---|--------|--|---|---|---|----------------------|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | 2b. HOUR
8:20 P M | |
| Ethel T. Satterfield | | | | | 3/24/69 19 | | | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | | 6 AGE (In years
last birthday) | 7 UNDER 1 YEAR
MONTHS DAYS | 7 UNDER 24 HRS
HOURS MIN | 2c. DATE PRONOUNCED DEAD
Month Day Year | |
| female | white | April 6, 1878 | | 92 YRS | 40 | | March 24 1969 | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | | | 2d. HOUR
8:20 P M |
| Ohio | | U.S.A. | | | Montgomery | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life given if retired) | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| Kensington | | Kensington Gardens Nursing Home | | | Housewife | | own home | |
| 13a. USUAL RESIDENCE (Where deceased lived,
admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | |
| Maryland | | Montgomery | | Kensington | | 5206 White Flint Drive | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| | | | | Timlin | unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | | |
| | | | | yes | William Satterfield 131 Doolan Court Florida | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF
<u>Arteriosclerotic Heart Disease</u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL
SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED | | | |
| EXAMINER'S
NAME (Type) | | Belden R. Keap, M.D. | | | 3/25/1969 | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Cremation | | March 24, 1969 | | St. Lincoln Crematory | | Bladensburg, Maryland | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Warner E. Pumphrey, Inc. 8434 Georgia Avenue
Silver Spring, Md. | | MAR 28 1969 | | | James J. Judge | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1 DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR A.M. or P.M. | |
|--|--|--|----------|---|---|--|--|---|------|
| Dallie | | Lucile | Saunders | March 11 1969 | | | 6:30 M | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| Female | | White | | 13 May 1937 | | 31 YRS | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Georgia | | USA | | | | Montgomery Md | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | The Clinical Center, NIH | | Housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Virginia | | Arlington | | Arlington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 804 North Cleveland Street | |
| 14 FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| Clisby | | | Jewell | | Loree | | | Wood | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | (If yes give year or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| No | | | | XXXXXXXXXX | | Bethesda, Maryland 20804
The Medical Records, The Clinical Center. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) | | PART I. DEATH WAS CAUSED BY. | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 7341 | | Cardiac arrest | | | | Hypertension, congestive heart failure | | 2 days | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | unknown | |
| | | | | | | (c) Systemic lupus erythematosus, lupus nephritis | | unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (A) (this hospital) attended the deceased from 8 January, 1969, to 11 March, 1969, that (X) (we) last saw the deceased alive on 11 March 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | EDWARD J. GOETZL, M.D., DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) | | Edward J. Goetzl, M.D. | | 22e. ADDRESS | | 11 March 1969
The Clinical Center, National Institutes of Health, Bethesda, Md. | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | March 14, 1969 | | Calvary Cemetery | | Fairfax, Virginia | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| C.M. Arnold | | Murphy Funeral Home
Arlington, Virginia 22204 | | March 14 1969 | | Charles Judge | | | |



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04230

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04222

| | | | | | | | |
|---|------------------|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or Print) <u>George</u> <u>WILLIAM</u> <u>Schaeffer</u> | | | 2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> Month <u>2</u> Year <u>1969</u> | | | 2b. HOUR <u>1:35</u> M. | |
| 3 SEX <u>M.</u> | 4 RACE <u>W.</u> | 5 DATE OF BIRTH <u>May 21, 1895</u> | 6 AGE (In years last birthday) <u>83</u> YRS | IF UNDER 1 YEAR
MONTHS <u>0</u> DAYS <u>0</u> | IF UNDER 24 HRS
HOURS <u>0</u> MIN <u>0</u> | 2c. DATE PRONOUNCED DEAD
Month <u>March</u> Day <u>2</u> Year <u>1969</u> | |
| 7a. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Montgomery</u> Md. | |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u> | | 13b. COUNTY <u>Montgomery</u> | | 13c. CITY OR TOWN <u>Bethesda</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER <u>4809 Steplmo Ave.</u> | | 14. FATHER'S NAME First <u>Willaim</u> Middle <u>Schaeffer</u> Last <u>Schaeffer</u> | | 15. MOTHER'S MAIDEN NAME First <u>Mary J.</u> Middle <u>Stone</u> Last <u>Stone</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16b. SOCIAL SECURITY NO <u>212-12-1547A</u> | | 17. INFORMANT <u>wife</u> ADDRESS <u>Same as Item 13.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia -</u>
<u>587X</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Fracture of Hip</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Arterio Sclerosis Generalized</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4 days -</u>
<u>15 days</u>
<u>years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Parkinson Syndrome</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <u>2/15</u> P.M. <u>1969</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
<u>Fell in nursing Home -</u> | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
<u>Nursing Home Grosvenor</u> | | 21f. LOCATION Street or R.F.D. No <u>Grosvenor Lane</u> City or Town <u>Bethesda</u> County <u>Montgomery</u> State <u>Md.</u> | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | EXAMINER'S NAME (Type) <u>JOHN G. BALL</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>March 2, 1969</u> | |
| ADDRESS <u>Bethesda, Md.</u> | | 23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u> | | 23b. DATE <u>3-5-69</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u> | |
| 23d. LOCATION (City or Town) <u>Bethesda, Maryland</u> | | 23e. LOCATION (County) <u>Montgomery</u> | | 23f. LOCATION (State) <u>Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. RECEIVED BY REGISTRAR <u>MAR 6 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>James Judge</u> | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04231

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04223

| | | | | | | | | |
|--|----------------------|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) <i>Keith L. Seegmiller</i> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Mar.</i> Day <i>9</i> Year <i>1969</i> | | | 2b. HOUR <i>6:30</i> M | | |
| 3. SEX <i>M.</i> | 4. RACE <i>White</i> | 5. DATE OF BIRTH <i>4/12/02</i> | 6. AGE (in years, last birthday) <i>66</i> YRS. <i>10</i> MONTHS <i>12</i> DAYS | IF UNDER 1 YEAR
HOURS MIN | | 2c. DATE PRONOUNCED DEAD
Month <i>Mar.</i> Day <i>9</i> Year <i>1969</i> | | 2d. HOUR <i>6:30</i> M |
| 7a. BIRTHPLACE (State or foreign country) <i>Utah</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md | | |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired) <i>Attorney</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Mont.</i> | | 13c. CITY OR TOWN <i>Kensington</i> | | 13d. INS DE CITY LIM 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>9615 Hillridge Rd.</i> |
| 14. FATHER'S NAME First <i>Charles L.</i> Middle <i>Seegmiller</i> Last <i>Ida</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Morris</i> Middle <i>Ida</i> Last <i>Morris</i> | | | 16. SOCIAL SECURITY NO <i>420-34-7806</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | 16b. (If yes give war or dates of service) | | 17. INFORMANT <i>Keith L. Stares</i> | | ADDRESS <i>3917 Lantern</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-4-17</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <i>March 9, 1969.</i> | | |
| EXAMINER'S NAME (Type) <i>John G. Ball</i> | | | ASS STANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>3-13-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i> | | 23d. LOCATION (City or Town) <i>Rockville</i> (County) (State) <i>Md.</i> | | |
| 24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i> ADDRESS <i>7557-Wisconsin Ave., Bethesda, Md.</i> | | | | 25a. REC'D BY REGISTRAR <i>MAR 14 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>Walter V. ...</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|------------------|--|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First Phyllis | | Middle A. | | Last Seips | | 2a. DATE OF DEATH
Month March Day 29 Year 1969 2b HOUR 2:24 AM | | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
May 29, 1893 | | | 6. AGE (In years last birthday)
75 YRS | | 7 UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country)
Illinois | | 7b CITIZEN OF WHAT COUNTRY?
U.S. America | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md | | | | | |
| 10 CITY OR TOWN OF DEATH
Takoma Park | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San + Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)
SECRETARY | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOV'T. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Resident before admission) STATE
Maryland | | | 13b. CITY OR TOWN
Prince George Green belt | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
17-H Parkway | | | |
| 14 FATHER'S NAME First Ross Middle Seips Last Seips | | | 15 MOTHER'S MAIDEN NAME First Eleanora Middle de Cesare Last de Cesare | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. 578-28-8559 | | | 17 INFORMANT
PT's Chart - | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Failure | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4125 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 14, 1969 , to March 29, 1969 , that (I) (we) last saw the deceased alive on March 28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Boris Robkin | | | | DEGREE
BORIS RABKIN | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
3-29-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
BORIS RABKIN | | | | 22e. ADDRESS
1019 Union Blvd East Silver Spring | | | | | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify)
BURIAL | | 23b. DATE
3-29-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
ALL SAINTS CEMETERY | | | | 23d. LOCATION (City or Town) (County) (State)
DES PLAINES, ILLINOIS | | | |
| 24. FUNERAL DIRECTOR
JOSEPH GAULIER & SONS, INC. | | | | 25a. REC'D BY REGISTRAR
5130 WISC. AVE. N.W., WASH., D.C. 20006 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

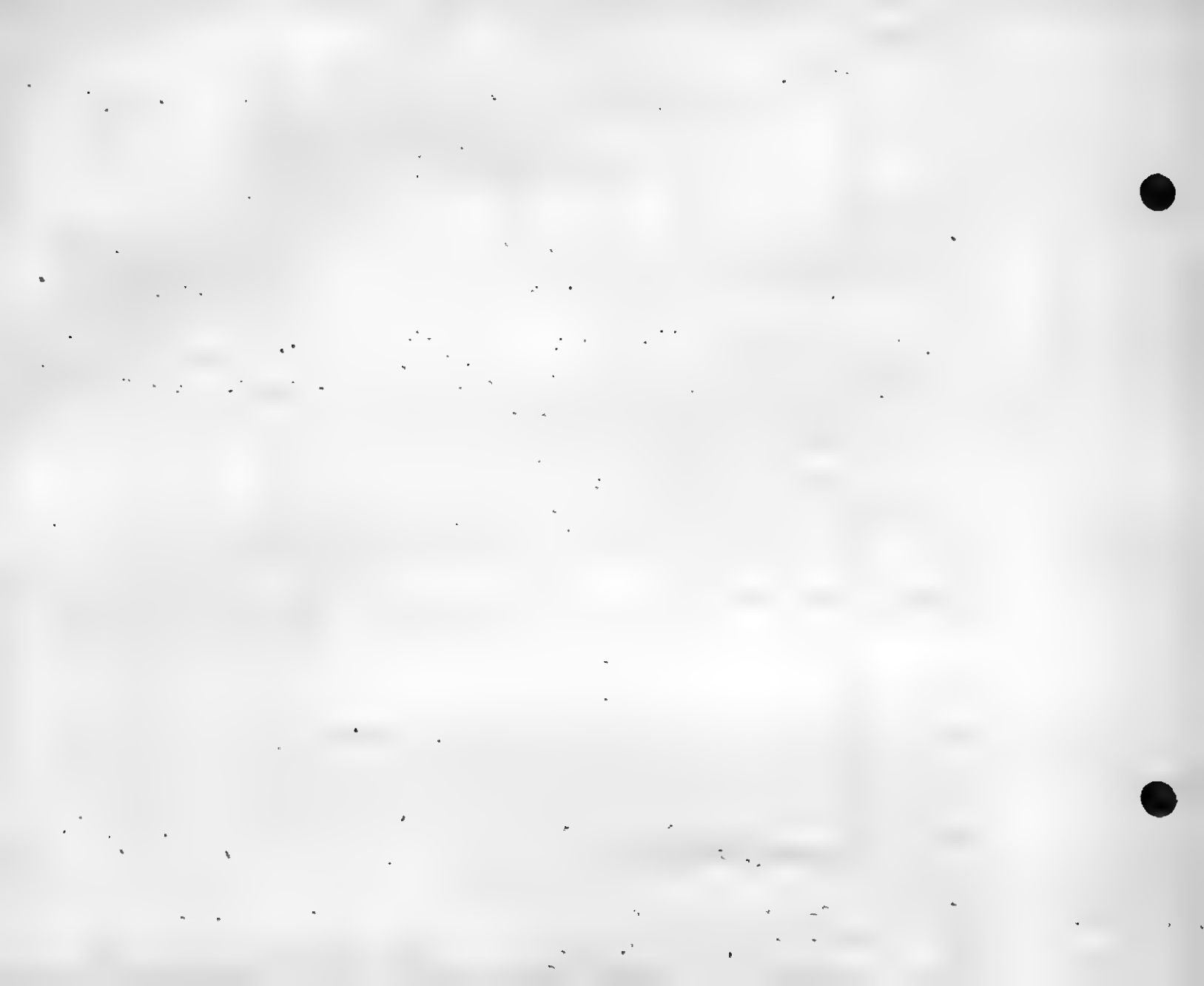
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|------------------------------|--|---|------------------------------------|---|---|--|--|--|--------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 04233 CERTIFICATE OF DEATH 04225 | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month Day Year | | |
| Margaret | | | Selby | | | | March | | 29 1969 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| Female | | White | | April 14, 1878 | | | 90 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Virginia | | U.S.A. | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Germantown | | | Box 263 | | | Housewife | | | home | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Montgomery | | | Germantown | | | | Box 263 | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | |
| Robert | | | Mahorney | | Mary | | Hudson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown] | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | |
| no | | | none | | | Mrs. Mary Benson | | | 7100 Muncaster Mill Rd., Derwood, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure.</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Terminal Pneumonia.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | County |
| | | | | | | | | | | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-5-68</u> , 19 <u>68</u> , to <u>3-22</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3-22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>L. J. Lent</u> | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>3-31-69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>L. J. Lent - M.D.</u> | | | | | | 22e. ADDRESS <u>Gaithersburg - Md</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| burial | | | 4-1-69 | | St. Mary's Cemetery | | | Rockville Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| ROBERT A. PUMPHREY | | | | | | ROCKVILLE, MD. | | DATE APR 7 1969 | | <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 04234 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04226 | |
|---|--|--|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Edith Mary Shannon</i> | | | | | 2a. DATE OF DEATH <i>Mar 23 1969</i> | | 2b. HOUR <i>5:00 PM</i> |
| 3 SEX <i>Female</i> | 4 RACE <i>W</i> | 5. DATE OF BIRTH <i>June 14-1882</i> | | 6. AGE (In years + last birthday) <i>86</i> YRS. | 7. UNDER 1 YEAR MONTHS | 8. UNDER 24 HRS. HOURS | 9. UNDER 24 HRS. MIN. |
| 7a. BIRTHPLACE (State or foreign country) <i>Md.</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>US</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <i>Montg.</i> Md. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Takoma Park</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>West Sun Hosp.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Clerical</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Montg.</i> | 13c. CITY OR TOWN <i>Takoma Park</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER <i>7300 Ballinowood</i> | | |
| 14. FATHER'S NAME First <i>James</i> Middle <i>Preston</i> Last <i>Shannon</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Josephine</i> Last <i>Evans</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or Unknown <i>No</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <i>577-12-7026A</i> | 17. INFORMANT <i>Eliz J Clark - 6306 N. Wales, Pk SE</i> Address <i>Wash. DC</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intestinal Pbt due to</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <i>Voluntary Cecum</i> | | | | | | | <i>1 day.</i> |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Shock</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Shock</i> | | | | | | | <i>5 hrs.</i> |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 10, 1967</i> , to <i>3/23/1969</i> , that (I) (we) last saw the deceased alive on <i>3/23/1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>5:50 PM</i> | | | | | | | |
| 22b. SIGNATURE <i>Howard J. Morse</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>3/23/69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Howard J. Morse</i> | | | | 22e. ADDRESS <i>7030 Carroll Ave Takoma Park Md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>3-27-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i> | |
| 24. FUNERAL DIRECTOR <i>Warner C. Pumphrey, Inc. 8434 Ga. Ave. Silver Spring, Md.</i> | | | | 25a. REC'D BY REGISTRAR <i>MAR 28 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the other Pages. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|------------------------|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(Type and last)
04235 DONALD RAY SHEETS | | First Middle Last | | 2a. DATE KNOWN OF DEATH
EST. <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/>
MATED <input type="checkbox"/> 3 26 69 LP M | | | | 2b. HOUR
LP M | | | |
| 3 SEX
Male | 4 RACE
White | 5. DATE OF BIRTH
12/14/42 | 6 AGE (In years last birthday)
26 25 YRS | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month 3 Day 26 Year 69 LP M | | | | 2d. HOUR
LP M | |
| 7a. BIRTHPLACE (State or foreign country)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
sheet metal worker | | | 12b. KIND OF BUSINESS OR INDUSTRY
NO STRY | | | |
| 13a. USLA. RESIDENCE (Where deceased lived, if not institution: Residence before address)
Silver Spring Md. | | 13b. CITY OR TOWN
SSMd. | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER
11459 Lockwood Dr. SSMd. | | | | | |
| 14. FATHER'S NAME
First Middle Last
Carl Sheets | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Elizabeth No Intyre Cookerly | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
yes | | 16b. SOCIAL SECURITY NO
577-406383 | | 17. INFORMANT
wife Carol | | ADDRESS
11459 Lockwood Dr. SSMd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive aspiration of gastric contents
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. due to auto accident
(b) due to auto accident
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
12:30 PM 3-26-69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 18, if in Part 2, item 18)
deceased, driving, collided with another vehicle. | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Street | | 21f. LOCATION Street or R.F.D. No
S. S. | | City or Town
Montg. | | County
Md. | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
3/26/1969 | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP, M.D. | | ADDRESS (Street, city, town, or county)
Ellicott City, Md. | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3-29-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Good Shepherd | | 23d. LOCATION (City or Town) (County) (State)
Ellicott City Md | |
| 24. FUNERAL DIRECTOR
Higginbottom-Slack | | ADDRESS
Ellicott City, Md. | | 25a. REC'D BY REGISTRAR
APR 1 1969 | | 25b. REGISTRAR'S SIGNATURE
J | | 25c. REGISTRAR'S NAME
J | | 25d. REGISTRAR'S ADDRESS
J | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04236

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH

04228

| | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|---------------------|----------------------------------|----------|--|--|---------------------------|--|
| 1 DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b HOJRA | | | | |
| John | | Henry | | SHULTZ | | March | | | Month 9 Day 69 Year | | | 1132 M | | | |
| 3 SEX | | 4. RACE | | 5 DATE OF BIRTH | | | | 6 AGE (In years last birthday) | | 7 UNDER YEAR | | IF UNDER 24 HRS | | | |
| Male | | Caucasian | | Dec. 6, 1901 | | | | 67 YRS | | 3 MONTHS | | 3 DAYS | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | |
| West Indies | | U.S.A. | | | | | | Montgomery Md. | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a U.S.A. OCCUPATION (Kind of work done during most of working life even if retired) | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| Bethesda | | Naval Hospital | | | | U. S. Navy | | | | N/A | | | | | |
| 13a. USJAL RESIDENCE (Where deceased lived, if institut on- Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | | | | | | | |
| Virgin Islands | | | | St. Croix | | | | Box 1453, Christiansted St. | | | | | | | |
| 14 FATHER'S NAME | | First | | Middle | | Last | | 15 MOTHER'S MA DEN NAME | | First | | Middle | | | |
| Paul | | Theodore | | Shultz | | | | Emma | | | | Pfiautz | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | | | College Carlisle | | Address | | Penn. | | | |
| Yes | | 1922-1952 | | 230 46 2124 | | | | Col. John M. Shultz, USA, | | Box 113, Army War | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | | | APPROXIMATE INTER-VAL, BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY- | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Stress ulcer-bleeding</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | |
| (b) <u>Renal tubular necrosis</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) <u>Villous adenoma, status post-operative</u> | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| <u>Multiple pulmonary emboli</u> | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner) | | 21b. TIME OF INJURY | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) | | | | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | | | | | | |
| 21d INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | | 21f LOCATION | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Jan. 31</u> , 19 <u>69</u> , to <u>Mar. 9</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>Mar. 9</u> , 19 <u>69</u> , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | | | | | | | 22c DATE SIGNED | | | |
| <u>Jack Ratliff</u> | | | | | | | | | | | | Mar. 10, 1969 | | | |
| 22d PHYSICIAN'S NAME (Type) | | | | | | | | | | | | 22e ADDRESS | | | |
| Jack Ratliff, M. D. | | | | | | | | | | | | Naval Hospital, Bethesda, Maryland | | | |
| 23a BURIAL CREMATION | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION (City or Town) | | (County) | | (State) | | | |
| Burial | | 3-14-69 | | Arlington National | | | | Arlington, | | Virginia | | | | | |
| 24 FUNERAL DIRECTOR | | | | | | | | | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |
| Robert A. Pumphrey Funeral Home | | | | | | | | | | | | MAR 14 1969 | | <u>William S. Judge</u> | |
| 7557 Wisconsin Ave., Bethesda, Md. | | | | | | | | | | | | | | | |



04229

04237

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|--|--|--|--|--|--|-------|--|---|--|------|--|---|--|--|--|--|--|---------------------------|--|--|--|
| 1 DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a DATE KNOWN
OF ESTI-
DEATH MATED | | Month | | Day | | Year | | 2b HOUR | | | | | | | | | |
| Reinhard | | Paul | | Sieving | | | | <input checked="" type="checkbox"/> | | 3 | | 6 | | 1969 | | 7:25 PM | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5 DATE OF BIRTH | | 6 AGE (in years
last birthday) | | IF UNDER 1 YEAR
MONTHS | | DAYS | | IF UNDER 24 HRS
HOURS | | MIN. | | 2c DATE PRONOUNCED DEAD | | | | | | | | | |
| Male | | White | | 6/5/04 | | 64 | | | | | | | | | | Month 3 Day 6 Year 1969 7:25 PM | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign
country) | | | | 7b CITIZEN OF WHAT COUNTRY? | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | |
| Indiana | | | | United States | | | | | | | | Montgomery Md | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INST-TUTION (If not in hospital
give street address) | | | | 12a USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | | | | 12b KIND OF BUSINESS OR
INDUSTRY | | | | | | | | | | | | | |
| Silver Spring | | | | Holy Cross Hosp. | | | | Lutheran Minister | | | | Religious | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if
admission) State | | | | 13b COUNTY | | | | 13c CITY OR TOWN | | | | 13d INSIDE CITY, HTS? | | | | 13e STREET AND NUMBER | | | | | | | | | |
| North Carolina | | | | Catawba | | | | Newton | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 130 Pinehurst Lane | | | | | | | | | |
| 14 FATHER'S NAME | | | | First | | | | Middle | | | | Last | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| | | | | | | | | | | | | | | | | ? Sieving ? | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16b SOCIAL SECURITY NO | | | | 17 INFORMANT | | | | ADDRESS | | | | | | | | | | | | | |
| No | | | | 242 522 647 | | | | Bernice wife | | | | same as above | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary insufficiency | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4123 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave
rise to immediate cause (a)
stating the underlying cause
lost. (b) Arteriosclerotic heart disease | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | | | | | | | | | |
| 10/25/68 | | | | | | Plastic Aortic Valve (Defective Aortic valve) | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | | | | 21b TIME OF INJURY Month Day, Year
HOUR A.M.
P.M. | | | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | |
| CAUSE OF DEATH | | | | | | 19 | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED | | | | | | 21e PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | | | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED | | | | | | | | | | | | | |
| EXAMINER'S
NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| Belden R. Reap, M.D. | | | | | | ADDRESS (Street, city, town, or county) | | | | | | March 7, 1969 | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION,
REMOVAL (Specify) | | | | | | 23b DATE | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | 23d LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | | | | | Mar 10, 1969 | | | | | | Newton Cemetery | | | | | | Newton Catawba N C | | | | | | | |
| 24 FUNERAL DIRECTOR | | | | | | | | | | | | ADDRESS | | | | | | 25a REC'D BY REGISTRAR | | | | 25b REGISTRAR'S SIGNATURE | | | |
| F. Gasch's Sons Hyattsville, Md. | | | | | | | | | | | | | | | | | | MAR 10 1969 | | | | J. Charles Judge | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM-9, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Belden R. Reap - Dr. Reap's Prop will sign

MEDICAL CERTIFICATION



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Fill in 411 MARYLAND STATE DEPARTMENT OF HEALTH
4-2-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04238

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04230

| | | | | | | | | | | | | | | | |
|--|--|--------|-------------------|--|--|---|--|--|----------------|------------------|--|---|--|--|--|
| 1 DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | | 2b. HOUR | | | |
| Charles | | | William | | | Smith | | | March 18 69 | | | 2:10 am | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | |
| Male | | Negro | | 10-22-24 | | 44 YRS | | MONTHS DAYS | | HOURS MIN | | 3 Month 18 Day 69 Year 19 | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | |
| Md. | | | | U. S. A. | | | | | | | | Montgomery Md | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Olney | | | | Montgomery General Hospital | | | | Sanitary Aid | | | | Health Dept. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | |
| Maryland | | | | Montgomery | | | | Olney | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13e. STREET AND NUMBER | | | | 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | |
| 17415 Old Baltimore Rd. | | | | First Middle Last | | | | First Middle Last | | | | (Yes, no or unknown) (If yes, give year or dates of service) | | | |
| | | | | William Smith | | | | Margaret Martin | | | | 16b. SOCIAL SECURITY NO. | | | |
| | | | | | | | | | | | | 17. INFORMANT | | | |
| | | | | | | | | | | | | Montgomery Gen. Hospital Records | | | |
| | | | | | | | | | | | | Olney, Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhagic pneumonitis, diffuse, bilateral | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month Day Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | HOUR A.M. P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 3/18/1969 | | | | | | | |
| Belden R. Reap M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| | | | | ADDRESS (City, town or county) | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or town) (County) (State) | | | |
| Burial | | | | 3-22-69 | | | | Sharp Street Church | | | | Sandy Spring, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert L. Snowden | | | | Rockville, Md. | | | | MAR 21 1969 | | | | [Signature] | | | |

CLEARED BY BELDON REAP, M.D. (CORONER)
2:30PM 3/26/69

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban/powers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04239

CERTIFICATE OF DEATH

04231

| | | | | | |
|---|-----------------|---|---|---|---|
| 1 DECEASED NAME
(Type or print) ^{First} EVA ^{Middle} J. ^{Last} Smith | | | 2a. DATE OF DEATH
3 Month 26 Day 69 Year | | 2b. HOUR
1:40 PM |
| 3. SEX
FEMALE | 4 RACE
WHITE | 5 DATE OF BIRTH
3/21/89 | | 6. AGE (In years last birthday)
80 YRS | 7. UNDER 1 YEAR
MONTHS DAYS |
| 7a BIRTHPLACE (State or foreign country)
Minnesota | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7c. COUNTY OF DEATH
MONTGOMERY | | 9. COUNTY OF DEATH
MONTGOMERY | | | |
| 10 CITY OR TOWN OF DEATH
SILVER SPRING | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS | | 12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.)
HOUSEWIFE | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
M.D. | | 13b COUNTY
MONTGOMERY | | 13c CITY OR TOWN
Silver Spring | |
| 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER
1908 GLEN ROSS ROAD | | | |
| 14 FATHER'S NAME
^{First} (unknown) ^{Middle} ^{Last} Colson | | 15 MOTHER'S MAIDEN NAME
^{First} (Unknown) ^{Middle} ^{Last} | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
No | | 16b SOCIAL SECURITY NO
215-48-6090 | | 17 INFORMANT
Silver Spring, Md.
Rev. Wm. R. Wooten, Jr. 1607 Grace Church Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u>
<u>4220</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CEREBRAL ATHEROSCLEROSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
(Cardinals, if any, which gave rise to immediate cause (a) stating the underlying cause last.) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>17 Days</u>
<u>1 YEAR</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>ARRHYTHMIC FIBRILLATION</u> | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No City or Town County State | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>SEPT. 9, 1955</u> to <u>MARCH 26, 1969</u> , that (I) (we) last saw the deceased alive on <u>3/26</u> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
<u>James A. Roberts</u> | | DEGREE
ATTENDING PHYSICIAN | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type)
JAMES A. ROBERTS | | 22e. ADDRESS
8907 GEORGIA AVE SILVER SPRING, MD. | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
April 2, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Prospect Hill Cemetery | |
| 23d LOCATION (City or Town) (County) (State)
Washington, D.C. | | | | | |
| 24. FUNERAL DIRECTOR
Warner E. Humphrey, Inc. Silver Spring, Md. | | 25. REC'D BY REGISTRAR
APR 3 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04240

CERTIFICATE OF DEATH

04232

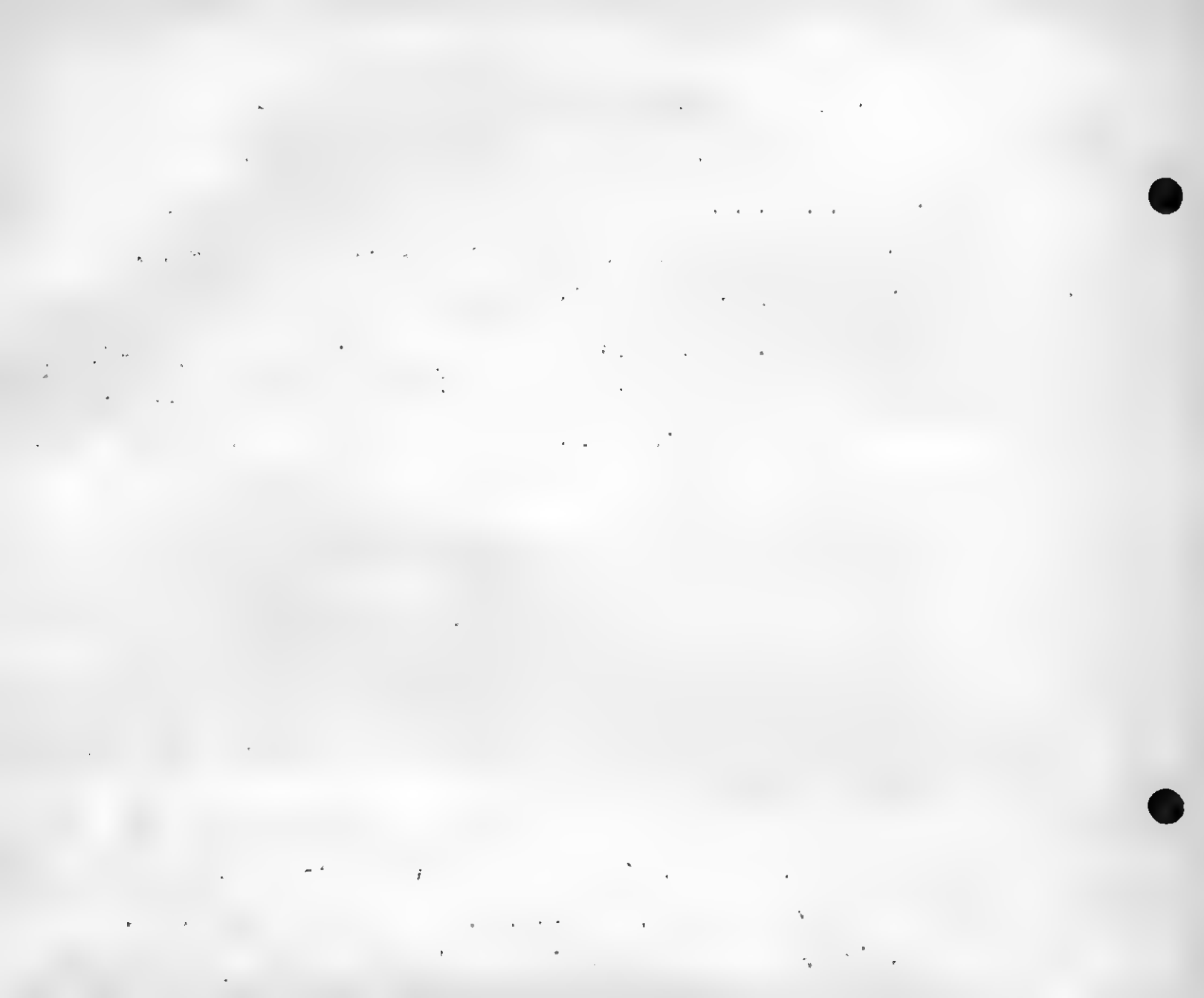
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Res. before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. LENGTH OF STAY IN 1b <u>Kensington</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>E.</u> Last <u>Smith</u> | | 4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1969</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-28-92</u> 76 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u> | | 11. BIRTHPLACE (County & State or foreign country) <u>Washington D.C.</u> | |
| 13. FATHER'S NAME <u>Francis E. Smith</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna T. Stack</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WAR I</u> | | 16. SOCIAL SECURITY NO <u>578 03 8693</u> | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute heart failure</u>
2509 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
(b) <u>Diabetes Mellitus</u>
DUE TO
(c) <u>Generalized arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>2 years</u>
<u>3 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>3/15</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/15</u> 19 <u>69</u> , and that death occurred at <u>TP</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John E. Everett</u> | | 22b. DATE SIGNED <u>3/15/69</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u> | | 22d. ADDRESS <u>9400 Conn. Ave. Kensington</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>3-19-69</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Mont. Md.</u> |
| 24. FUNERAL DIRECTOR <u>Francis J. Collins</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |
| ADDRESS <u>500 University Blvd. W. Silver Spring, Md.</u> | | DATE <u>MAR 20 1969</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 04241 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04233 | | | | | |
|---|--|--|--|--|---|--|--|--|--|------------------|--|
| 1. DECEASED NAME (Type or print) | | | | | 2a. DATE OF DEATH | | 2b. HOUR | | | | |
| Marie Josephine Smith | | | | | Month March Day 30 Year 1969 | | 5:15 PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER YEAR MONTHS DAYS | | | |
| Female | | White | | 7 August 1945 | | 23 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Washington, D.C. | | U.S.A. | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | The Clinical Center, NIH | | | Telephone Service Rep. | | | unemployed | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY, IN 157 | | 13e. STREET AND NUMBER | | |
| Maryland | | | Prince Georges | | Hyattsville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4818 Glenoak Road | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| Albert H. Di Tizio | | | Marjorie Saarikoski | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | | | | | |
| no | | | 217-44-6938 | | The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland 20014 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease (Extensive tumor of the viscera) | | | | | | | | | 4 years | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Cond trans, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 13 February 1969, to 30 March, 1969, that (we) lost saw the deceased alive on 30 March 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| David A. Bray, MD. | | | | | | | | | | 30 March 1969 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | | |
| | | | | | The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | (County) (State) | | |
| Burial | | 4/3/69 | | Ft. Lincoln Cem. | | | Colmar Manor, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Nalley's Funeral Home Inc. | | | | | DATE APR 7 1969 | | | Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|--|------|---|--|--|----------------------------------|--|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | |
| William Horace Smith | | | | | | 3 Month 3 Day 23 Year 69 | | | 5:45 A | | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| Male | | White | | 8-20-10 | | 58 YRS. | | | | | |
| 7a BIRTHPLACE (State or foreign try) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Mississippi | | U.S.A. | | | | Montgomery Md. | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | | | Holy Cross Hosp. | | | Statistician | | | Gov't. | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| Md. | | | Montgomery | | | Sil. Spr. | | | | 12102 Bushey Drive | |
| 14 FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Albert Poole Smith | | | | | | Mattie Biggs | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes <input checked="" type="checkbox"/> | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT Address | | | | | |
| W.W. II | | | | | | Sammie W. Smith - 12102 Bushey Dr. S.S. Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION | | | | | | | | | | SUDDEN | |
| DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DISEASE, DECOMPENSATED | | | | | | | | | | 5 YEARS | |
| DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION AND ARTERIOSCLEROSIS | | | | | | | | | | 10 YEARS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| PULMONARY CARCINOMA, HEPATIC FAILURE, CIRRHOSIS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY, 1959, to MARCH 21, 1969, that (I) (we) last saw the deceased alive on 3/21 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | |
| A. EARL VIVINO, MD | | | | | | | | | | 3/23/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| A. EARL VIVINO, MD | | | | | | 2500 WISCONSIN AVE NW | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | March 26, 1969 | | Lakewood Cemetery | | Jackson, Mississippi | | | | | |
| 24. FUNERAL DIRECTOR | | 24a ADDRESS | | 25a REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Warner E. Pumphrey, Inc. | | 8434 Georgia Avenue Silver Spring, Md. | | MAR 28 1969 | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
|--|---------------|---|---|--|---|--|--|---|
| Fred | | | | Smithies | March | 12 | Day | 1969 |
| 3 SEX | Male | | 4 RACE | White | | 5. DATE OF BIRTH | May 27, 1894 | |
| 7a BIRTHPLACE (State or foreign country) | Mass | | 7b. CITIZEN OF WHAT COUNTRY? | USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Montgomery | |
| 10. CITY OR TOWN OF DEATH | Silver Spring | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Holy Cross | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIM TS? | | 13d. STREET AND NUMBER |
| Maryland | | | | Montgomery | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2210 Henderson Avenue |
| 14 FATHER'S NAME | | | First | Middle | Last | 15 MOTHER'S MAIDEN NAME First Middle Last | | |
| George | | | Smithies | Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO | | | 17 INFORMANT | | |
| yes | | | 577-09-6933-A | | | Mrs. Elva C. Smithies 2210 Henderson Ave., Wheaton, Maryland | | |
| 18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> | | | | | | | | 2 days |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Myocardial Infarction</u> | | | | | | | | 2 days |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Generalized Atherosclerosis</u> | | | | | | | | years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/10/69</u> to <u>3/12/69</u> , that (I) (we) last saw the deceased alive on <u>3/12/69</u> , and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED |
| <u>John J. Curry MD</u> | | | | | | | | <u>3/13/69</u> |
| 22d. PHYSICIAN NAME (Type) | | | | 22e. ADDRESS | | | | |
| John J. Curry | | | | 9801- Georgia Avenue Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION
REMOVE (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) |
| Burial | | March 15, 1969 | | St. Lincoln Cemetery | | Bladensburg, Maryland | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Md. | | | | DATE MAR 19 1969 | | <u>William J. Moore</u> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

04244

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04236

| | | | | | |
|--|------------------------|---|--|---|---|
| 1. DECEASED NAME
(Type or print) Mary VIRGINIA Gorsell | | | 2a. DATE OF DEATH
Month 3 Day 19 Year 69 | | 2b. HOUR
1:40 P M |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH
Jan 29 1885 | | 6 AGE (in years last birthday)
84 YRS | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 |
| 7a BIRTHPLACE (State or foreign country)
Wash DC | | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH
Montgomery Md |
| 10 CITY OR TOWN OF DEATH
Kensington | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Kensington Gardens Nursing Home | | 12a USJA. OCCUPAT ON (Kind of work done during most of working life, even if retired)
Homemaker | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
Md | | 13b COUNTY
Montgomery | 13c CITY OR TOWN
SLICE SPRING | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER
1520 Jasper St Silver Spring |
| 14 FATHER'S NAME
First Cyrus Middle M Last Allen | | 15 MOTHER'S/MAIDEN NAME
First Lillis Middle Ella Last Moulden | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or (unknown) NO (If yes give war or dates of service) | | 16b SOCIAL SECURITY NO
220-54-045751 | | 17 INFORMANT
Ethel B Stephens Address Rt 2 Watersville Rd Mt Airy Md | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic cerebral vascular disease
4370 DUE TO, OR AS A CONSEQUENCE OF (b) dissection
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 yrs |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Essential hypertension 2) bronchial asthma | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> hot while <input type="checkbox"/>
at work at work | | 21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC) | | 21f LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/29, 1966 to 3/19, 1969 , that (I) (we) last saw the deceased alive on 3/19, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
[Signature] | | 22c. PHYSICIAN'S NAME (Type)
H F Kreuzburg | | 22d. ADDRESS
7852 16th NW Wash DC | |
| 23a BURIAL CREMATION, REMOVAL (Specify)
Burial | | 23b DATE
3-22-69 | | 23c NAME OF CEMETERY OR CREMATORY
Mt Zion Cemetery | |
| 24 FUNERAL DIRECTOR
Robert A Pumphrey | | 25a REC'D BY REGISTRAR
MR 24 1969 | | 25b REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

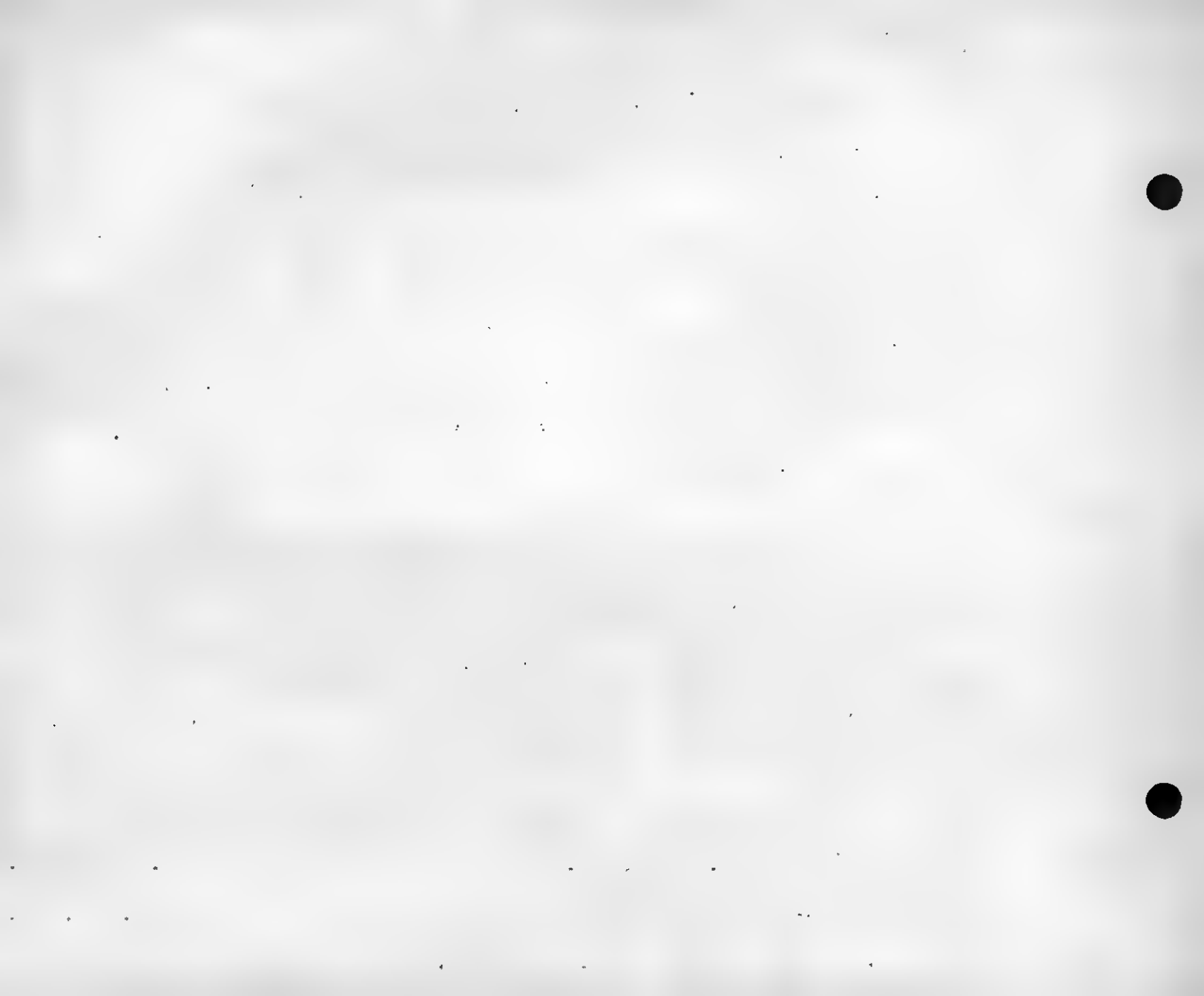
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Helen | | | Middle
S. | | | Last
Sowers | | | 2a. DATE OF DEATH
Month Day Year
March 20- 1969 | | | 2b. HOUR
5:20 PM | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
10/9/1882 | | | 6. AGE (In years
lost birthday)
86 YRS. | | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | 8. IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
Michigan | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Wheaton Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Housewife | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Own Home | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before
admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Kensington | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
11008 Glueck Lane | | | | | |
| 14. FATHER'S NAME
First Middle Last
Smith Henry J. | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Helen Adelia Moulton | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
521-48-2738 | | | 17. INFORMANT
Address
Don C. Sowers, Jr. (son) 11008 Glueck Lane | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) Brain Stem Stroke
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebral Arteriosclerosis | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory)
OFFICE BUILDING, ETC. | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1965, to March 20, 1969, that (I) (we) lost
saw the deceased alive on March 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Robert T. Thibodeau | | | DEGREE | | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
3-20-69 | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Robert T. Thibodeau | | | 22e. ADDRESS
11000 Old Georgetown Rd., Rockville, Md. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
3/22/69 | | | 23c. NAME OF CEMETERY OR CREMATORY
Spring Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Spring Hill, Kansas | | | | | | | | |
| 24. FUNERAL DIRECTOR
p. J. Smith
Warner E. Pumphrey, Inc. Silver Spring, Maryland | | | 25a. REC'D BY REGISTRAR
MAR 24 1969 | | | 25b. REGISTRAR'S SIGNATURE
James G. Judge | | | | | | | | | | | |

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(5)
'68

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and one copy within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|--|--------------------------|--|-----------------|--|-----------------|---|--|
| 04247 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | 04239 | |
| 1. DECEASED NAME (Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | |
| CAMILLA | | NIELSEN | | STARR | | 2b. HOUR | | 12 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD |
| Fe. | W | Jan. 6, 1920 | | 49 YRS. | MONTHS DAYS | | HOURS MIN | | Month March 13 Year 1969 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | |
| New York | | U.S.A. | | WIDOWED | | DIVORCED | | Montgomery | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cherry Chase | | 7701 Meadow Lane | | | | None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Md. | | Montgomery | | Cherry Chase | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 7701 Meadow Lane | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO | | | |
| First Middle Last | | | First Middle Last | | | 17. INFORMANT ADDRESS | | | |
| Hans | | | Nielsen | | | Philip T. Starr AS ABOVE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT ADDRESS | | | |
| | | | | | | AS ABOVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASPHYXIA - | | | | | | | | | |
| 1972 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) OVERDOSE OF DRUGS TRANQUILIZERS & HYPNOTICS 1/2 hr.? | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | HOUR PM 3 11 1969 | | Took overdose of Nodulon, Ekonal, Somnux. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| | | Home | | 7701 Meadow Lane Cherry Chase | | Montgomery | | Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER | | ASSISTANT MEDICAL EXAMINER | | DEPUTY MEDICAL EXAMINER | |
| John G Ball | | John G Ball | | | | | | 22b. DATE SIGNED | |
| | | | | | | | | March 13, 1969 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or town) | | 23e. REGISTRAR'S SIGNATURE | |
| Burial | | 3-15-69 | | Parklawn Cemetery | | Rockville Pr. Geo Md | | 7936 Old Gertown Bethesda, Md Rd | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md | | | | MAR 19 1969 | | [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
45M 1-69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|---|--|-------|--|--|--|---|--|--|--|--|--|--|--|--|---------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 04248 | | 04240 | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | | Middle | | | Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | |
| Victor | | | M. | | | Stephens. | | | | | | 3-22-69 | | | 11:00 PM | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | | 8. IF UNDER 24 HRS
HOURS MIN | | |
| MALE | | | white | | | 4-9-04 | | | 64 YRS | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | |
| HARBIN Manchuria | | | U.S.A. | | | | | | Montgomery | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| Bethesda | | | Suburban | | | Distributor | | | Auto Tires | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | |
| Md. | | | Montgomery | | | Bethesda | | | YES | | | 5948 Avon Drive | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | | | | |
| Michael T. Stephens | | | MATRONA - SCHEKERENKO | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | | | | | | | |
| No | | | | | | Helen Stephens | | | 5948 Avon Drive | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | | | | | | | | | | | 12 Hr | | | | | |
| 4319 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis | | | | | | | | | | | | 4 YRS- | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1964, to Jan 1969, that (I) (we) last saw the deceased alive on Jan 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | | | |
| W. H. Killay M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 22c. DATE SIGNED 3-23-69 | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Wm. H. Killay | | | | | | | | | | | | | | | | | |
| 22e. ADDRESS 8218 WIS. AVE, BETHESDA, MD. | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | |
| BURIAL | | | 3-26-69 | | | ROCK CREEK CEM. | | | WASHINGTON, D.C. | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | | | |
| J. S. Crawford 5130 Wisconsin Ave N.W. WASHINGTON, D.C. | | | | | | | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR DATE MAR 26 1969 | | | | | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE Charles J. J. J. | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|------------------------------|--|--|------------------------------------|---|--|--|------------------------|
| 04249 | | | | | | | | | |
| 04241 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Maurice William Stevenson | | | | | | 3 Month 12 Day 69 Year | | | M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Male | | Negro | | 12/12/09 | | 59 YRS | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Washington, D.C. | | USA | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Wheaton | | | University Nursing Home | | | Dishwasher | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| D.C. | | | 3b. COUNTY | | Washington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1413 1st Street |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| William Henry Stevenson | | | Edna Daleman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | |
| No | | | 579-10-7884 | | Lorrie Stevenson | | 22- Todd Rd NE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cerebrovascular occlusion</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cerebrovascular disease</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>decease</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No | | City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>28 Jan. 1969</u> to <u>12 Mar. 1969</u> , that (I) (we) last saw the deceased alive on <u>11 March 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | |
| Walter Booght MD | | | 12 March 69 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | |
| Walter Booght | | | 2396 Ringwood in Wheaton, Md | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or town) (County) (State) | | |
| Burial 3-17-69 | | | 13-17-69 | | Hawthorn Cemetery | | Baltimore, Md | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| John D. Watson, Watson's Funeral Home | | | MAR 13 1969 | | | Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04250

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04242

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|---|
| 1 DECEASED NAME
(Type or print) First Middle Last
Nancy Carol Stolzenberger | | | 2a. DATE OF DEATH
Month Day Year
March 7 1969 | | 2b. HOUR P
9:00M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
31 March 1946 | | 6. AGE (in years
last birthday)
22 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country)
New Jersey | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
The Clinical Center | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Sec-Stenographer | | 12b. KIND OF BUSINESS OR
INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before
admission) STATE
New Jersey | 13b. COUNTY
69 | 13c. CITY OR TOWN
Irvington | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
21 Allen Street | |
| 14. FATHER'S NAME First Middle Last
Martin Stolzenberger | | 15. MOTHER'S MAIDEN NAME First Middle Last
Helen Reichardt | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO.
156-36-6878 | | 17. INFORMANT The Medical Records Address
The Clinical Center, NIH, Bethesda, Md. 20014 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Hodgkin's Disease involving liver/lymph nodes
DUE TO, OR AS A CONSEQUENCE OF
(b) Hemorrhage of wall of cecum/surrounding tissues
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 year
12 hours |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
yes | | 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | |
| 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that IX (this hospital) attended the deceased from 17 Jan. 1969, to 7 March 1969, that IX (we) last saw the deceased alive on 7 March 1969, and that in IX (our) opinion death occurred on the date and hour and from the causes stated above, IX (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Clarence H. Brown, III, M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
3-7-69 | |
| 22d. PHYSICIAN'S
NAME (Type)
Clarence H. Brown, III, M.D. | | 22e. ADDRESS The Clinical Center, National
Institutes of Health, Bethesda, Md. 20014 | | | |
| 23a. BURIAL, CREMAT. ON,
REMOVAL (Specify)
Burial | 23b. DATE
3-12-69 | 23c. NAME OF CEMETERY OR CREMATORY
St. Peters Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Garfield, New Jersey | |
| 24. FUNERAL DIRECTOR
ADDRESS
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. RECD BY REGISTRAR
DATE
MAR 12 1969 | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
45M

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|-----------------------------|-------|--|--------|-----------------------------------|---|---|--|----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR |
| INFANT GIRL STREET | | | | | | | | 3 Month 11 Day 69 Year | | 1400 PM |
| 3 SEX | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN | |
| FEMALE | WHITE | | 3/11/69 | | | | | | 2 10 | |
| 7a BIRTHPLACE (State or foreign country) | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | |
| MARYLAND | U.S.A. | | | | MONTGOMERY | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| BETHESDA | | | SUBURBAN HOSPITAL | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| MARYLAND | | | MONTGOMERY | | WHEATON | | | | 12304 CHARLES RD. | |
| 14. FATHER'S NAME First Middle Last | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| DELMAR STREET | | | WANDA MANIS | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or of unknown (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | Address | | | |
| | | | | | FATHER | | SAME | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) PULMONARY ATELECTASIS | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) IMMATURITY | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| | | | | | | | | | | |
| 21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21c LOCATION Street or R.F.D. No City or Town County State | | | | |
| | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 3/11, 1969, to 3/11, 1969, that (I) (we) last saw the deceased alive on 3/11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c DATE SIGNED |
| Joseph F. McKelvie MD | | | | | | | | | | 3/11/69 |
| 22d PHYSICIAN'S NAME (Type) | | | | | | 22e ADDRESS | | | | |
| | | | | | | | | | | |
| 23a BURIAL/CREMATION REMOVAL (Specify) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | |
| | | | 3/14/69 | | Suburban Hospital | | Bethesda - Montg. - MD | | | |
| 24 FUNERAL DIRECTOR | | | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | |
| Mrs. Amelia C. Carter, Administrator | | | | | | MAR 17 1969 | | [Signature] | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released by Med Exam Dr. Keap

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--------|---|-----------------|--|---|--|---------------------------|--|---------------------------|--|
| 04252 | | | | | | | | | | | |
| 04244 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | |
| ROBERT | | | D. | | | STUTZEL | | | 3 XX 24 XX 69 XX 7:10A | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| Male | | White | | 2/17/69 | | 2 | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Washington D.C. | | | USA | | | | | | Montgomery Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Silver Spring | | | Holy Cross Hospital | | | minor | | | none | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Maryland | | | Prince Georges | | | Beltsville | | | 13e. STREET AND NUMBER | | |
| | | | | | | | | | 11380 Cherry Hill Rd. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Dennis | | | Stutzel | | | Pamela | | | ? | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| none | | | | | | father Dennis | | | 11380 Cherry Hill Rd, Beltsville | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Fever of unknown origin</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) <u>Probable Interstitial pneumonia</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2/17, 1967</u> to <u>3/24, 1969</u> , that (I) (we) last saw the deceased alive on <u>Not Recently</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE <u>Ralph Stiller, M.D.</u> | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED <u>March 24, 1969</u> | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. Ralph Stiller</u> | | | | | | 22e. ADDRESS <u>1110 Spring Street Silver Spring Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | Mar. 27, 1969 | | | Elmwood Cemetery | | | Dewitt Clinton Iowa | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| F. Gasch's Sons Hyattsville, Md. | | | | | | MAR 27 1969 | | | <u>J. J. Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04253

CERTIFICATE OF DEATH

04245

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) JAMES LEO SULLIVAN | | | 2a. DATE OF DEATH
Month 3 Day 24 Year 1969 | | | 2b. HOUR
5:00 AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
10/18/84 | | 6. AGE (In years last birthday)
84 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
N.Y. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Wheaton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital street address)
Randolph Hills Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
RETIRED - PRINTER | | 12b. KIND OF BUSINESS OR INDUSTRY
NEWSPAPERS | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Res before admittance) STATE D.C. | | 13b. COUNTY D.C. | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY, Y.N.S.P. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
4700 N.W. Ave N.W. | |
| 14. FATHER'S NAME
First MICHAEL Middle SULLIVAN Last SULLIVAN | | | 15. MOTHER'S MAIDEN NAME
First ETELKA Middle M. Last SULLIVAN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO
578-09-9442 | | 17. INFORMANT
Address STATE ST #13
MRS. ETELKA M. SULLIVAN, WIDOW | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT (MULTIPLE)
4370
DUE TO, OR AS A CONSEQUENCE OF
(b) GENERALIZED ATHEROSCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) HYPERTENSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
AUG 69 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
PROSTATISM & URINARY RETENTION & INFECTION | | | | | | | |
| 19a. DATE OF OPERATION
NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
— | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
— | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
— | | 21f. LOCATION Street or R.F.D. No. City or Town County State
— | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug , 1968, to 3/24 , 1969, that (I) (we) last saw the deceased alive on 3/9 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert L. Flynn MD | | | | DEGREE
MD | | 22c. DATE SIGNED
3/24/69 | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT L. FLYNN MD | | | | 22e. ADDRESS
916 19th ST NW WASH DC | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-26-1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
Joseph J. Sullivan Son | | ADDRESS
5730 Woodlawn NW | | 25a. REC'D BY REG. STRAR
MAR 26 1969 | | 25b. REGISTRAR'S SIGNATURE
William J. Jones | |

04254

CERTIFICATE OF DEATH

04246

| | | | | | | | | |
|--|------------------------------|---|---|--|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
PM | |
| Infant Boy | | Sweeney | | | March 14 69 | | 6:35 PM | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Male | White | | March 14, 1969 | | YRS. | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country) | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | United States | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| Silver Spring | | Holy Cross | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | Prince George | | Hyattsville | | 2013 Oglethorpe Street | | |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | First | Middle |
| Michael Kern Sweeney | | | | | Janet mae Bryant | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Address | | | | |
| | | | | Mother | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Prematurity (6 mos gestation)</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC) | | 21f. LOCATION Street or RFD No. | | City or Town | | County |
| | | | | | | | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Joseph A. Dugan, M.D.</u> | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-14-69 | |
| 22d. PHYSICIAN'S
NAME (Type)
Joseph A. Dugan, M.D. | | | | | 22e. ADDRESS
50 W. Edmonston Dr. Rockville, Md. | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) |
| Burial | | 3/20/69 | | Gate of Heaven Cemetery | | Silver Spring, Md. | | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler | | 1309 Rockville Pike
Rockville, Md. | | 25a. REC'D BY REGISTRAR
MAR 26 1969 | | 25b. REGISTRAR'S SIGNATURE
William J. Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04255

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04247

| | | | | | | | |
|--|------------------|--|--|---|---------------------------|--|-------------------------|
| DECEASED NAME
(Type or Print) <u>Greer Margaret Sweitzer</u> | | First Middle Last | | 2a DATE KNOWN OF DEATH <input type="checkbox"/> Month Day Year <u>March 22 1969</u> | | 2b HOUR <u>7:30 AM</u> | |
| 3 SEX <u>Fe</u> | 4 RACE <u>W.</u> | 5 DATE OF BIRTH <u>Jan 31 1882</u> | 6 AGE (In years last birthday) <u>87</u> YRS | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN | 2c DATE PRONOUNCED DEAD Month Day Year <u>March 22 1969</u> | 2d HOUR <u>10:30 AM</u> |
| 7a BIRTHPLACE (State or foreign country) <u>Penna.</u> | | 7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH <u>Montgomery</u> | |
| 10 CITY OR TOWN OF DEATH <u>Damascus</u> | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>9313 Gue. Rd.</u> | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 2b KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u> | | 13b COUNTY <u>Montgomery</u> | | 13c CITY OR TOWN <u>Damascus</u> | | 3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last <u>Daniel W. Bretzman</u> | | 15. MOTHER'S MAIDEN NAME First Middle Last <u>SARAH MARTHA HYSON</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16b SOCIAL SECURITY NO <u>220-44-9241</u> | | 17 INFORMANT <u>daughter - Evelyn Sweitzer Fite</u> ADDRESS <u>same</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u> | | | | | | <u>Sudden.</u> | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiovascular Disease -</u> | | | | | | <u>years.</u> | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ | | 21b TIME OF INJURY Month, Day Year _____ P.M. 19 _____ | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) _____ | | | |
| 21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) _____ | | 21f LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____ | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> | | 22b DATE SIGNED <u>March 22, 1969</u> | |
| EXAMINER'S NAME (Type) <u>John G. Ball</u> | | DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) _____ | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>3/25/69</u> | | 23c NAME OF CEMETERY OR CREMATORY <u>Stewartstown Cem.</u> | | 23d LOCATION (City or Town) (County) (State) <u>Stewartstown, York Co., Pa.</u> | |
| 24. FUNERAL DIRECTOR <u>Benjamin W. Ashburn</u> | | ADDRESS <u>Stewartstown, Pa.</u> | | 25a REC'D BY REGISTRAR <u>MAR 26 1969</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles George</u> | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
TOM REV 1/68

Items 10&22a Film 411 MARYLAND STATE DEPARTMENT OF HEALTH
4-3-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04248

Item #6, Film 10110 3/21/69 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | |
|--|-----------------------------|---|--|--|
| 1. DECEASED NAME
First Middle Last
DELLA M THOMAS | | 2a. DATE KNOWN OF DEATH
Month Day Year
3 15 1969 | | 2b. HOUR
7:20 A.M. |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
9-4/87 | 6. AGE, in years (last birthday)
81 YRS | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
MONTGOMERY Md. |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOLY CROSS HOSP. | | 12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)
HOUSEWIFE |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE
MD. | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SILVER SP. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
First Middle Last
ANDREW HAILSLIP | | 15. MOTHER'S MAIDEN NAME
First Middle Last
SARAH CHURCH | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16b. SOCIAL SECURITY NO
WA-258975 | | 17. INFORMANT
PHILIP THOMAS |
| | | ADDRESS
10100 QUINBY ST. SILVER SP. MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral infarction; | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis, severe | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE
Belden R. Keap | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
3/15/1969 |
| EXAMINER'S NAME (Type)
BELDEN R. KEAP M.D. | | ADDRESS (Street, City, Town, or County)
200 E. Main St., Silver Spring, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE
March 18, 1969 | 23c. NAME OF CEMETERY OR CREMATORY
M.T. HOME | 23d. LOCATION (City or Town) (County) (State)
EAST ST. LOUIS ILLINOIS | |
| 24. FUNERAL DIRECTOR
PUMPHREY FUNERAL HOME | | ADDRESS
8434 Ga. Ave. Silver Spring, Md. | | REC'D BY REGISTRAR
DATE MAR 20 1969 |
| | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach on papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04258

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04249
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1 DECEASED-NAME
(Type or print) First Middle Last
Dorsey L Thompson | | | 2a. DATE OF DEATH
Month Day Year
March 19 1969 | | | 2b. HOUR
M
 | |
| 3. SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
Nov. 30, 1880 | | 6 AGE (In years last birthday)
88 YRS | |
| 7a BIRTHPLACE (State or foreign country)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | |
| 10 CITY OR TOWN OF DEATH
Wheaton | | 11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)
1916 University Blvd. W. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Retired - Farmer | | 12b KIND OF BUSINESS OR INDUSTRY
 | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b CITY OR TOWN
Wheaton | | 13c INSIDE CITY LIMITS
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d STREET AND NUMBER
1916 University Blvd., West | |
| 14 FATHER'S NAME First Middle Last
Millard Thompson | | | 15 MOTHER'S MAIDEN NAME First Middle Last
Julia Duwall | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
no | | 16b SOCIAL SECURITY NO
yes | | 17 INFORMANT
Address Wheaton, Md.
Mrs. James Brown, 1916 University Blvd., West | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Probable myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) accident
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Severe Cirrhosis & Ascaris | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19 1969 , to March 19 1969 , that (I) (we) last saw the deceased alive on Mar. 19 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R. Bufalino | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
Mar. 19 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
Russell Bufalino | | | | 22e. ADDRESS
1429 University Blvd. West, Silver Spring | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b DATE
March 22, 1969 | | 23c NAME OF CEMETERY OR CREMATORY
St. John's Cemetery | | 23d LOCATION (City or Town) (County) (State)
Forest Glen, Mont., Maryland | |
| 24 FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | | | 25a. REC'D BY REG STRAR
DATE
MAR 24 1969 | | 25b. REG. STRAR'S SIGNATURE
Charles J. Jones | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04257

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04250

| | | | | | | | | |
|--|------------------|---|---|---|------------------------------|---|--|---|
| 1 DECEASED NAME
(Type or Print) <i>James E Thompson</i> | | | 2a DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 3 16 1967 | | | 2b HOUR <i>4:45</i> M | | |
| 3 SEX <i>M.</i> | 4 RACE <i>W.</i> | 5 DATE OF BIRTH <i>Oct. 8, 1915</i> | 6 AGE <i>53</i> YRS | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN | 2c DATE PRONOUNCED DEAD
Month <i>March</i> Day <i>16</i> Year <i>1967</i> | | |
| 7a BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 COUNTY OF DEATH <i>Montgomery</i> Md. | | |
| 10 CITY OR TOWN OF DEATH <i>Bethesda</i> | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>5917 Ralston Rd.</i> | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Restaurant</i> | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution) STATE <i>Md.</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c CITY OR TOWN <i>Bethesda</i> | | 13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e STREET AND NUMBER <i>5917 Ralston Rd.</i> |
| 14 FATHER'S NAME <i>Edward Howard Thompson</i> | | | 15 MOTHER'S MAIDEN NAME <i>Julia Frances Owens</i> | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> | | 16b SOCIAL SECURITY NO. <i>WW 11 577-26-9678</i> | | 17. INFORMANT <i>Brother George Al Thompson</i> | | ADDRESS <i>Same as Item 13.</i> | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis Acute</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Coronary Arteriosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>50 days</i>

<i>years</i> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <i>19</i> | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or RFD No | | City or Town | | County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE <i>John G. Ball</i> | | EXAMINER'S NAME (Type) <i>JOHN G. BALL</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <i>March 16, 1967</i> | | |
| ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i> | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b DATE <i>3-19-69</i> | | 23c NAME OF CEMETERY OR CREMATORY <i>Baltimore Natl Cem.</i> | | 23d LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i> | | |
| 24 FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | | | ADDRESS | | 25a REC'D BY REGISTRAR <i>MAR 24 1969</i> | | 25b REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 501 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04259

CERTIFICATE OF DEATH

04259

| | | | | | |
|--|--|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Beulah Edna Tilley | | | 2a. DATE OF DEATH
Month Day Year
March 11 1969 | | 2b. HOUR A M
6:05 M |
| 3. SEX
Female | | 4. RACE
White | 5. DATE OF BIRTH
1 December 1908 | | 6. AGE (In years lost birthday)
60 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
North Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
North Carolina | | 13b. COUNTY
V | 13c. CITY OR TOWN
Kernersville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
Route # 6 |
| 14. FATHER'S NAME First Middle Last
William A. Ashley | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Eva Baines | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO
Not Available | | 17. INFORMANT Bethesda, Maryland 20814
The Medical Records, The Clinical Center, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cryptococcal Meningitis
1160
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 Months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (X) (this hospital) attended the deceased from 25 January, 1969, to 11 March, 1969, that (X) (we) last saw the deceased alive on 11 March 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert R. Rich, M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
11 March 1969 | |
| 22d. PHYSICIAN'S NAME (Type)
Robert R. Rich, M. D. | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
3-13-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Garden of Memory | |
| 23d. LOCATION (City or Town) (County) (State)
Walkerstown N. C. | | | | | |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey 7557 Wisc.Ave Beth, Md | | ADDRESS | | 25a. REC'D BY REGISTRAR
MAR 14 1969 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

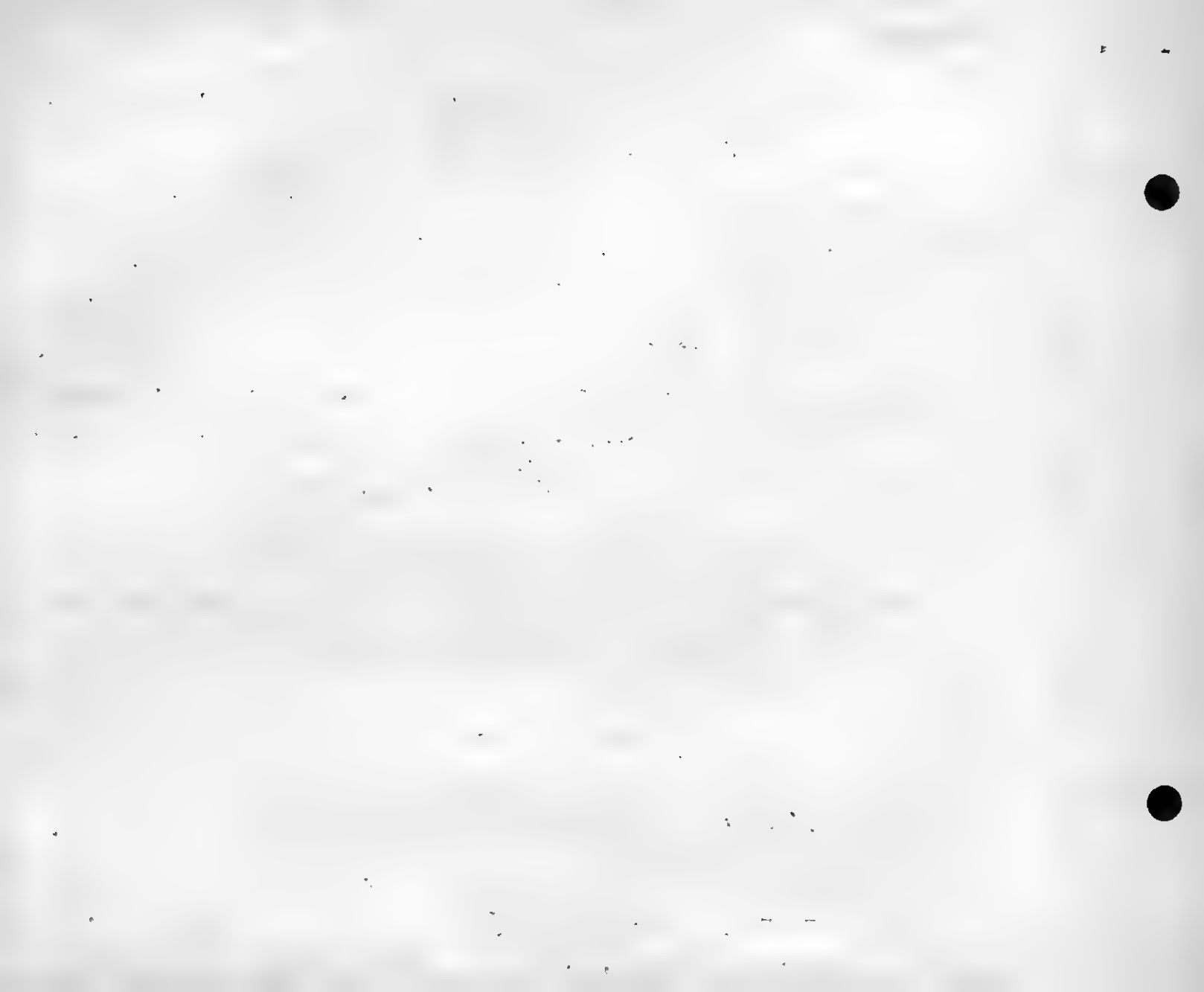
04260

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04252

CERTIFICATE OF DEATH

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED-NAME
(Type or print) LOUISE First H. Middle TISDALE Last | | | 2a. DATE OF DEATH
Month 3 Day 11 Year 1969 | | 2b. HOUR
5:05 PM |
| 3. SEX
Female | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
11-19-1892 | | 6. AGE (In years
lost birthday)
96 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country) ILLINOIS | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10. CITY OR TOWN OF DEATH
CHEVY CHASE | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital,
give street address) BETHESDA-SILVER SPRING
NURSING HOME | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
TEACHER | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MD/DC | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Washington | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 5324
Wapakoneta Rd Wash DC | |
| 14. FATHER'S NAME First FREDERICK Middle HEIDENRICK Last | | | 15. MOTHER'S MAIDEN NAME First ANNA Middle MEYERHOLZ Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
ROSA D Tisdale Address 5324
Wapakoneta Rd Wash DC | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrombosis Middle cerebral artery
DUE TO, OR AS A CONSEQUENCE OF arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 weeks | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1907 , 19____, to____, 19____, that (I) (we) last saw the deceased alive on MARCH 8, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Edward W. Youngblood, M.D. DEGREE | | 22c. DATE SIGNED
March 11, 1969 | | 22d. ADDRESS
Washington & Irving Wash, D.C. | |
| 22e. PHYSICIAN'S NAME (Type)
Edward W Youngblood | | | | | |
| 23a. BURIAL OR CREMATION,
REMOVAL (Specify)
Burial | 23b. DATE
3-15-69 | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Township | | 23d. LOCATION (City or Town) (County) (State)
Zearing Iowa | |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
MAR 14 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04261

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04253

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Bessie Edith Trainer | | | 2a. DATE OF DEATH
Month Day Year
March 4 1969 | | | 2b. HOUR
M
 | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
4-13-85 | | 6. AGE (In years last birthday)
83 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
Amer | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington San E Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
NONE | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Sandy Springs | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
Joseph Ward | | 15. MOTHER'S MAIDEN NAME First Middle Last
Margaret Frazier | | 13e. STREET AND NUMBER
17401 Norwood Road. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO
Unknown | | 17. INFORMANT Address
Hospital Record | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the bladder
188X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
hemorrhage from bladder | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1967 to 3-4 , 1969, that (I) (we) last saw the deceased alive on 3-3 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
M Snow M.D. | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
3-4-69 | |
| 22d. PHYSICIAN'S NAME (Type)
M. SNOW MD | | | | 22e. ADDRESS
9013 Flower Ave Silver Spring | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify)
Burial | | 23b. DATE
Mar 7 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Whitell Township Prince Georges | |
| 24. FUNERAL DIRECTOR
James H. Jones | | | | 25a. REC'D BY REGISTRAR
James H. Jones | | 25b. REGISTRAR'S SIGNATURE
James H. Jones | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and no any event within 72 hours after death.

04262

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04254

| | | | | | | | | |
|--|------------------------|--|---|--|--------------------------------|--|--|---|
| 1 DECEASED NAME
(Type or Print) <i>Lucille S. Tinsman</i> | | | 2a DATE KNOWN OF DEATH
Month <i>March</i> Day <i>23</i> Year <i>1969</i> | | | 2b HOUR
<i>4:30</i> PM | | |
| 3 SEX
<i>F</i> | 4 RACE
<i>Negro</i> | 5 DATE OF BIRTH
<i>3/14/32</i> | 6 AGE
(In years last birthday) <i>37</i> YRS | 7 UNDER 1 YEAR
MONTHS
DAYS | 8 UNDER 24 HRS
HOURS
MIN | 2c DATE PRONOUNCED DEAD
Month <i>March</i> Day <i>23</i> Year <i>1969</i> | | 2d HOUR
<i>4:30</i> PM |
| 7a BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Montgomery</i> Md | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before address) STATE
<i>Maryland</i> | | | 13b COUNTY
<i>Mont.</i> | | | 13c CITY OR TOWN
<i>Poolesville</i> | | 3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
First <i>John I.</i> Middle <i>Samuel</i> Last <i>Marion Hall</i> | | | 15 MOTHER'S M.A.DEN NAME
First <i>Marion</i> Middle <i>Hall</i> Last <i>Hall</i> | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) | | |
| 16b SOCIAL SECURITY NO | | | 17 INFORMANT
<i>John I. Senior</i> | | | ADDRESS
<i>Same as above (father)</i> | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute pancreatitis</i>
<i>1770</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 weeks</i> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Fatty cirrhosis of liver (chronic alcoholism)</i> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | |
| 21d. INJURY OCCURRED WHILE - AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL EXAMINER'S SIGNATURE
<i>John G. Ball</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED
<i>March 24, 1969</i> | | |
| EXAMINER'S NAME (Type) | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL (Cremation)
<i>Buried</i> | | | 23b. DATE
<i>3-27-69</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Elijah Church.,</i> | | |
| 23d. LOCATION (City or Town)
<i>Poolesville, Md.</i> | | | 23e. COUNTY
<i>Montgomery</i> | | | 23f. STATE
<i>Md.</i> | | |
| 24. FUNERAL DIRECTOR
<i>Robert L. Snow</i> | | | ADDRESS
<i>Rockville, Md.</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 28 1969</i> | | |
| 25b. REGISTRAR'S SIGNATURE
<i>Wm. L. Carter</i> | | | | | | | | |



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04263

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04255

| | | | | | | | | | | |
|--|--------|--|--------|--|------------------------|---|-----------------|--|------------------------------|---------|
| 1 DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a DATE KNOWN OF DEATH | | Month | Day | Year | 2b HOUR |
| Howard | | Smink | Ynger | | DATE ESTIMATED | | 3 | 12 | 1969 | 1 A M |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (in years last birthday) | IF UNDER 1 YEAR | | F UNDER 24 HRS. | | 2c DATE PRONOUNCED DEAD | |
| M. | W. | Sept 5/1905 | | 63 YRS | MONTHS DAYS | | HOURS MIN. | | Month March Day 12 Year 1969 | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | 2d HOUR |
| Penna. | | U.S.A. | | WIDOWED | | DIVORCED | | Montgomery | | 7 A M |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| Bethesda. | | 5939 Anniston Rd. | | ESTIMATOR | | CONSTRUCTION | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | | |
| Md. | | Montgomery | | Bethesda | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5939 Anniston Rd. | | |
| 14. FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS |
| George | | Clara | | no | | — | | Knight Funeral Home, Williamsport Penna. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| IMMEDIATE CAUSE (a) | | 4124 | | coronary Insufficiency Acute. | | Sudden | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | cardio vascular Disease | | years | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b TIME OF INJURY Month Day Year | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| CAUSE OF DEATH | | 19 | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State |
| | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22b DATE SIGNED | | March 12, 1969 | | | | |
| ACTUAL SIGNATURE | | John S. Ball | | M.D. | | | | | | |
| EXAMINER'S NAME (Type) | | | | | | | | | | |
| 23a BURIAL CREMATION REMOVAL (Specify) | | 23b DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) |
| REMOVAL - BURIAL | | 3-13-1969 | | GREENLAWN MEMORIAL PARK | | CLINTON, LYCOMING CO., PENNA. | | | | |
| 24 FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | |
| JOSEPH GAULER'S SONS, INC. | | 5130 WISC. AVE | | MAR 17 1969 | | | | | | |
| | | N.W. WASH., D.C. | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|---|---|--|--|
| 04264 | | CERTIFICATE OF DEATH | | | | | | | | 04256 | | |
| 1. DECEASED-NAME
(Type or print) KEVIN LYNN VREDENBURG | | | | | | 2a. DATE OF DEATH
MARCH Month 28 Day 1969 Year | | | 2b. HOUR
530A M | | | |
| 3 SEX
MALE | | 4 RACE
CAUCASIAN | | 5. DATE OF BIRTH
6 AUGUST 1963 | | | 6. AGE (In years last birthday)
5 YRS. | | 7. UNDER 1 YEAR
MONTHS 7 DAYS 23 | | 8. UNDER 24 HRS.
HOURS 7 MIN 23 | |
| 7a. BIRTHPLACE (State or foreign country)
CALIFORNIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY COUNTY Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
NAVAL HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
N/A | | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
13b. COUNTY | | | 13c. CITY OR TOWN
LEXINGTON PK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
RT#2, BOX 107142 | | |
| 14. FATHER'S NAME First Middle Last
EUGENE K VREDENBURG | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
YOSHICA IZUMI | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO
— | | 17. INFORMANT Address | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) TETRALOGY OF FALLOT
1462
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) POST-OP RIGHT SUBCLAVIAN ARTY. TO PULMONARY
DUE TO, OR AS A CONSEQUENCE OF ARTY SHUNT
(c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
27MAR69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
TETRALOGY OF FALLOT | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY)
OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 17 MARCH , 19 69 , to 28 MARCH , 19 69 , that XX (we) last saw the deceased alive on 28 MARCH , 19 69 , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above, XX (we) (did) XX view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
W. E. BEASLEY, M.D. | | | | | | DEGREE
— | | ATTENDING PHYS.
<input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type)
W. E. BEASLEY, M.D. | | | | | | 22e. ADDRESS
NAVAL HOSPITAL, BETHESDA, MARYLAND | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | | 23b. DATE
4-1-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | | 23d. LOCATION (City or Town) (County) (State)
Arlington Virginia | | | | | |
| 24. FUNERAL DIRECTOR
1557-1558 in Ave., Bethesda, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE APR 3 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

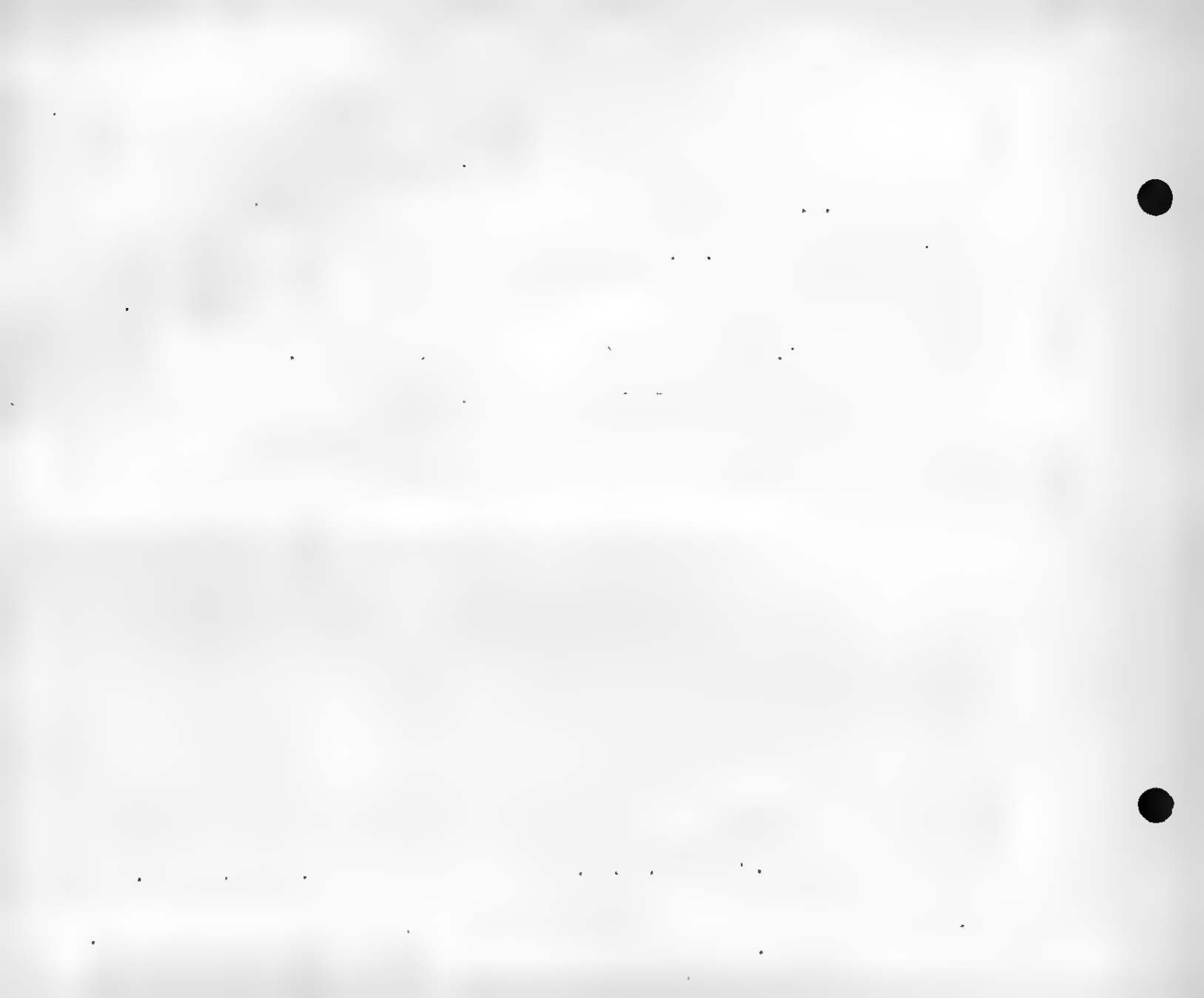
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with a 72-hour after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|---|---|---|---|--|---|----------------------------------|-----------------------|--|
| 04265 | | CERTIFICATE OF DEATH | | | | | | 04257 | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2a DATE OF DEATH | | 2b HOUR | | |
| Maria Antonieta Fortes WAGNER | | | | | | March 19 1969 | | 1120 M | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| Female | | Caucasian | | March 26, 1912 | | 56 YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Brazil | | Brazil | | | | Montgomery | | N/A | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | Naval Hospital | | | Housewife | | N/A | | |
| 3a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | |
| S. Dakota | | | Codington | | Watertown | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1403 West Kemp Avenue | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Artur - Fortes | | | Guilhermina - Alcantara | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO | | 17. INFORMANT | | | | | |
| No | | | None | | Watertown, South Dakota
Mr. Edmund G. Wagner, 1403 West Kempt Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Carcinoma breast with widespread metastases | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Mar. 10, 1969, to Mar. 19, 1969, that (X) (we) lost the deceased alive on Mar. 19, 1969, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did (or did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Theodore H. Wilson, Jr. DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED March 20, 1969 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Theodore H. Wilson, Jr., M.D. | | 22e ADDRESS Naval Hospital, Bethesda, Maryland | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 3-24-69 | | Baltimore National Cemetery | | Baltimore Maryland | | | | |
| 24 FUNERAL DIRECTOR Joseph Gawler Sons ADDRESS | | | | 25a REC'D BY REGISTRAR DATE | | 25b REGISTRAR'S SIGNATURE | | | | |
| 5130 Wisconsin Ave., N. W. Washington, D. C. | | | | MAR 26 1969 | | [Signature] | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

| 04266 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04258 | |
|---|--|---|---|--|---|---|---|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | |
| Annette Jean WALLACE | | | | | | MARCH 8 1969 | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6. AGE (In years last birthday) | |
| FEMALE | | CAUC | | 8 APRIL 1921 | | 47 YRS. | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | |
| WASHINGTON, D.C. | | UNITED STATES | | | | MONTGOMERY Md | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | |
| BETHESDA | | | U. S. NAVAL HOSPITAL | | | HOUSEWIFE | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| MARYLAND | | | MONTGOMERY | | OLNEY | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | |
| Clifton A. KOESTER | | | RUTH A. WINDAS | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT (Husband) Address | | |
| No | | | 577-20-4229 | | John G. Wallace-3408 Colonial Court, Olney, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the breast with metastases | | | | | | | |
| 174X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (d) (this hospital) attended the deceased from 26 FEB, 1969, to 8 MARCH, 1969, that (x) (we) last saw the deceased alive on 8 MARCH 1969, and that in (d) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (d) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
Robert C. Cochran | | | | | 22c. DATE SIGNED
10 MARCH 1969 | | |
| 22d PHYSICIAN'S NAME (Type)
Robert C. Cochran, M. D. | | | | | 22e ADDRESS
Naval Hospital, Bethesda, Md. | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | |
| Burial | | March 11, 1969 | | Arlington National Cemetery Arlington Va. | | | |
| 24 FUNERAL DIRECTOR
Warner E. Pumphrey Funeral Home
Silver Spring, Maryland | | | | 25a REC'D BY REGISTRAR
MAR 14 1969 | | 25b REGISTRAR'S SIGNATURE
Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04267

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04259

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) John Arthur Wallace | | | 2a. DATE OF DEATH
Month Day Year
March 30, 1969 | | | 2b. HOUR MIN
12:20 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
1 October 1912 | | 6. AGE (in years
lost birthday)
56 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign
country)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
The Clinical Center, NIH | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Owner | | 12b. KIND OF BUSINESS OR
INDUSTRY
Machine Co. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before
admission) STATE
West Virginia | | 13b. COUNTY
Oak Hill | | 13c. CITY OR TOWN
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER
401 Jones Avenue | |
| 14. FATHER'S NAME First Middle Last
Peter I. Wallace | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Maude Nicholson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give year or dates of service)
yes 1942-46 | | 16b. SOCIAL SECURITY NO.
233-54-7903 | | 17. INFORMANT The Medical Record Address The Clinical
Center, NIH, Bethesda, Maryland 20014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pseudomonas Septicemia</u>
<u>1538</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>Bronchopneumonia (bilateral)</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Adenocarcinoma of colon</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
48 Hours
48 Hours
2 Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? <u>yes</u> | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <u>XX</u> (this hospital) attended the deceased from <u>5 March</u> , 19 <u>69</u> , to <u>30 March</u> , 19 <u>69</u> , that <u>XX</u> (we) last
saw the deceased alive on <u>30 March</u> , 19 <u>69</u> , and that in <u>XX</u> (our) opinion death occurred on the date and hour and from the
causes stated above, <u>(X)</u> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>William C. Wood MD</u> | | | | DEGREE ATTENDING <input type="checkbox"/> MED <input type="checkbox"/> STAFF <input checked="" type="checkbox"/>
PHYS. DIRECTOR PHYS. | | 22c. DATE SIGNED
30 March 1969 | | | |
| 22d. PHYSICIAN'S
NAME (Type) William C. Wood, MD. | | | | 22e. ADDRESS The Clinical Center, National
Institutes of Health, Bethesda, Md. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
4-1-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Silver Spring | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring Md | | | |
| 24. FUNERAL DIRECTOR Francis J. Collins, ADDRESS
500 Univ. Blvd. W. Silver Spring, Md. | | | | 25a. REC'D BY REGISTRAR
DATE APR 3 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|---|---|--|----------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 04268 CERTIFICATE OF DEATH 04260 | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 20. DATE OF DEATH
Month Day Year | | | 2b HOUR A M |
| Brian James Wandless | | | | | | March 23 1969 | | | 2:10 A M |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | | 6 AGE (In years
lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS |
| Male | | White | | February 2, 1965 | | | 4 YRS | | IF UNDER 24 HRS.
HOURS MIN |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Washington, DC. | | U.S.A. | | | | Montgomery Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Bethesda | | | The Clinical Center | | | Child | | | |
| 13a USUAL RES DENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | |
| Virginia | | | Arlington | | Arlington | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2844 South Buchanan Street | |
| 14 FATHER'S NAME First Middle Last | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| James N. Wandless | | | Carolyn (NMN) Boughner | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT The Medical Record Address | | | | |
| No | | | None | | The Clinical Center, NIH, Bethesda, Md 20014 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
2040 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Severe proctitis
DUE TO, OR AS A CONSEQUENCE OF
(c) Acute lymphocytic leukemia | | | | | | | | | APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
Hours
Days
10 months |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that xx (this hospital) attended the deceased from 15 March, 1969, to 23 March, 1969, that xx (we) lost saw the deceased alive on 23 March, 1969, and that in xx (our) opinion death occurred on the date and hour and from the causes stated above, xx (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Alan Snyder</i> | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
March 23, 1969 | | |
| 22d. PHYSICIAN'S NAME (Type)
Alan L. Snyder, M.D. | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Md 20014 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3-27-69 | | Doupin Cemetery | | Doupin, Doupin Co. Pa. | | | |
| 24. FUNERAL DIRECTOR | | 7557 Wisconsin Ave. | | REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| ROBERT A. PUMPHERY | | Bethesda, Maryland | | MAR 26 1969 | | <i>Charles Judge</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove expiration papers (page 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET AND NUMBER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Immaturity</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> , 19 <u>69</u> , to <u>3/7</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>3/7</u> , 19 <u>69</u> , and that (an) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04270

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04262

| | | | | | | | | | | | | | |
|---|--------|---|--|---|--|---|--|---|------------------------|---|--|-----------------------|--|
| 1 DECEASED NAME
(Type or Print) | | First | | Middle | | Last | | 2a DATE KNOWN OF EST DEATH <input checked="" type="checkbox"/> Month Day Year | | | | 2b HOUR | |
| Camille | | EGNER | | Washburn. | | 3-1-1969 | | | | 10 ¹⁵ P.M. | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | F UNDER 24 HRS | | 2c DATE PRONOUNCED DEAD | | 2d HOUR | |
| Fe. | W. | Dec 18 1896 | | 72 YRS | | MONTHS DAYS | | HOURS MIN | | March Day 1969 | | 10 ¹⁵ P.M. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | | | |
| Missouri | | U.S.A. | | Montgomery Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | Suburban | | | | HOUSEWIFE | | | | | | | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | | | | | |
| Md. | | Montgomery | | Kensington | | | | 10100 Hadley Place | | | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | | First Middle Last | | | | | | | | | |
| William Frederick Egner | | | | Beryl Mansfield Fish | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | | ADDRESS | | | | |
| | | | | 161-38-1796 | | MRS ALBERT E. BEITZEL, SISTER | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage Massive. | | | | | | | | | | | 18 hrs | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease | | | | | | | | | | | Years | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day, Year | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | | | HOUR A.M. P.M. 19 | | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No. | | | City or Town | | County State | | |
| | | | | | | | | | | | | | |
| 22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | March 2, 1969 | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | |
| | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION (City or Town) | | (County) | | (State) Md. | |
| Burial | | 3-5-1969 | | Cedar Hill Cemetery | | | | Suitland | | Prince Georges | | County | |
| 24 FUNERAL DIRECTOR | | | | | | ADDRESS | | | 25a REC'D BY REG STRAR | | 25b REGISTRAR'S SIGNATURE | | |
| Joseph J. Ball's Sons, Inc., 5130 Haco Ave. | | | | | | Washington, D.C., 20016 | | | MAR 10 1969 | | Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|--|---|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 04271 CERTIFICATE OF DEATH 04263 | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a DATE OF DEATH | | 2b HOUR | | |
| RACHEL | | | H. WATKINS | | | March Month 20 Day 1969 Year | | 4:30 PM | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | |
| Female | | White | | Feb. 28, 1891 | | 78 YRS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Wisconsin | | USA | | | | Montgomery Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Rockville | | | residence | | | Housewife | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY (Y/N) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Montgomery | | Rockville | | | | 107 W. Jefferson St. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| Unknown | | | Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> N | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT Address | | | | | |
| | | | | | Maryland 20906
Hanson Watkins-3227 BelPre Rd. Silver Spring | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> | | | | | | | | | ONE HOUR | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> | | | | | | | | | 20 YEARS | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERY DISEASE</u> | | | | | | | | | 20 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>NEPHROSCLEROSIS</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 13, 1969, to MARCH 20, 1969, that (I) (we) last saw the deceased alive on MARCH 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Gordon S. Rosenberger</u> | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED MARCH 20, 1969 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger | | | | 22e. ADDRESS 310 WEST MONTGOMERY AVE ROCKVILLE, MARYLAND | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 3/24/69 | | Arlington National | | Arlington, Virginia | | | | |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md. | | | | 25a. REC'D BY REGISTRAR DATE MAR 26 1969 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | |



04272

CERTIFICATE OF DEATH

04264

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1 DECEASED NAME
(Type or print) ELLIS | | First Middle Last L. WEAKLEY | | 2a DATE OF DEATH
Month March Day 24 Year 1969 | | 2b HOUR
940 A.M. | |
| 3 SEX
m | | 4 RACE
WHITE | | 5. DATE OF BIRTH
12-9-99 | | 6 AGE (In years
last birthday)
69 YRS | |
| 7a. BIRTHPLACE (State or foreign
country) VA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY Md. | |
| 10 CITY OR TOWN OF DEATH
SILVER SPRING MD. | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) HOLY CROSS Hosp | | 12a USUAL OCCUPATION (Kind of work done
during most of work ng life, even if retired.)
Pressman | | 12b KIND OF BUSINESS OR
INDUSTRY
Printing | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MD. | | 13b COUNTY MONTGOMERY | | 13c CITY OR TOWN
WHEATON | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
First Middle Last
Acie Weakley | | 15 MOTHER'S MA DEN NAME
First Middle Last
Elizabeth Broyles | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | | |
| 16b SOCIAL SECURITY NO
214-03-8337A | | 17 INFORMANT
Address Wheaton
Ethel B. Weakley-12203 Livingston St., Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) wall, left ventricle. | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute myocardial infarction posterior | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF artery. | | | | | | | |
| (b) Thrombotic occlusion, right coronary | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) Arteriosclerotic heart disease. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1960 , to MARCH 24, 1969 , that (I) (we) last
saw the deceased alive on MARCH 24, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Edward A. Beerman M.D. DEGREE | | | | ATTENDING <input checked="" type="checkbox"/> MED <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYS. DIRECTOR PHYS. | | 22c. DATE SIGNED
MARCH 24, 1969 | |
| 22d. PHYSICIAN'S
NAME (Type) EDWARD A. BEEMAN | | | | 22e. ADDRESS
1015 SPRING ST.
SILVER SPRING MD 20910 | | | |
| 23a B. RIAL, CREMAT ON,
REMOVAL (Specify)
Burial | | 23b. DATE
March 27, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Burtonsville Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Spencerville, Maryland | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. | | 8434 ADDRESS
Georgia Avenue | | 25a REC'D BY REGISTRAR
MAR 28 1969 | | 25b REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I have been thinking of you
and wondering how you are getting on.
I hope you are well and happy.
I have been very busy lately,
but I will try to write to you
more often in the future.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 04273 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04265 | |
|--|---------------------|---|--|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
ELIZABETH DEFANDORF WEAVER | | | 2a. DATE OF DEATH Month Day Year
Mar 10 1969 | | 2b. HO. JR.
825P, M | | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MAY 18, 1890 | | 6. AGE (In years lost birthday)
78 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN
9 22 | | |
| 7a. BIRTHPLACE (State or foreign country)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
MONTGOMERY | |
| 10. CITY OR TOWN OF DEATH
GARRETT PARK | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
4509 Oxford St | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Md. | | 13b. COUNTY
Montg | | 13c. CITY OR TOWN
GARRETT PARK | | 13d. INSIDE CITY, N.Y.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
4509 Oxford St. | | 14. FATHER'S NAME First Middle Last
Jas Fremont Defandorf | | 15. MOTHER'S MAIDEN NAME First Middle Last
Harriet Holmes | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
217-46-7000 | | 17. INFORMANT Charles R. Weaver Address
6922-Woodside Pl., Chevy Chase, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4123 Cardiac Infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac-Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c) 8-10 years | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 1943 to March 10, 1969 , that (I) (we) last saw the deceased alive on March 5, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Katharine A. Chapman, M.D. | | | | 22c. DATE SIGNED
March 10, 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Katharine A. Chapman | | | | 22e. ADDRESS
3924 Baltimore St. Kensington, Md. | | | |
| 23a. DATE OF CREMATION, BURIAL, OR INTERMENT (Specify)
3-11-69 | | 23b. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23c. LOCATION (City or Town) (County) (State)
Suitland Maryland | | | |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS
7557-Wisconsin Ave., Bethesda, Md. | | | | 25a. REG. BY REGISTRAR
MAR 14 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04274

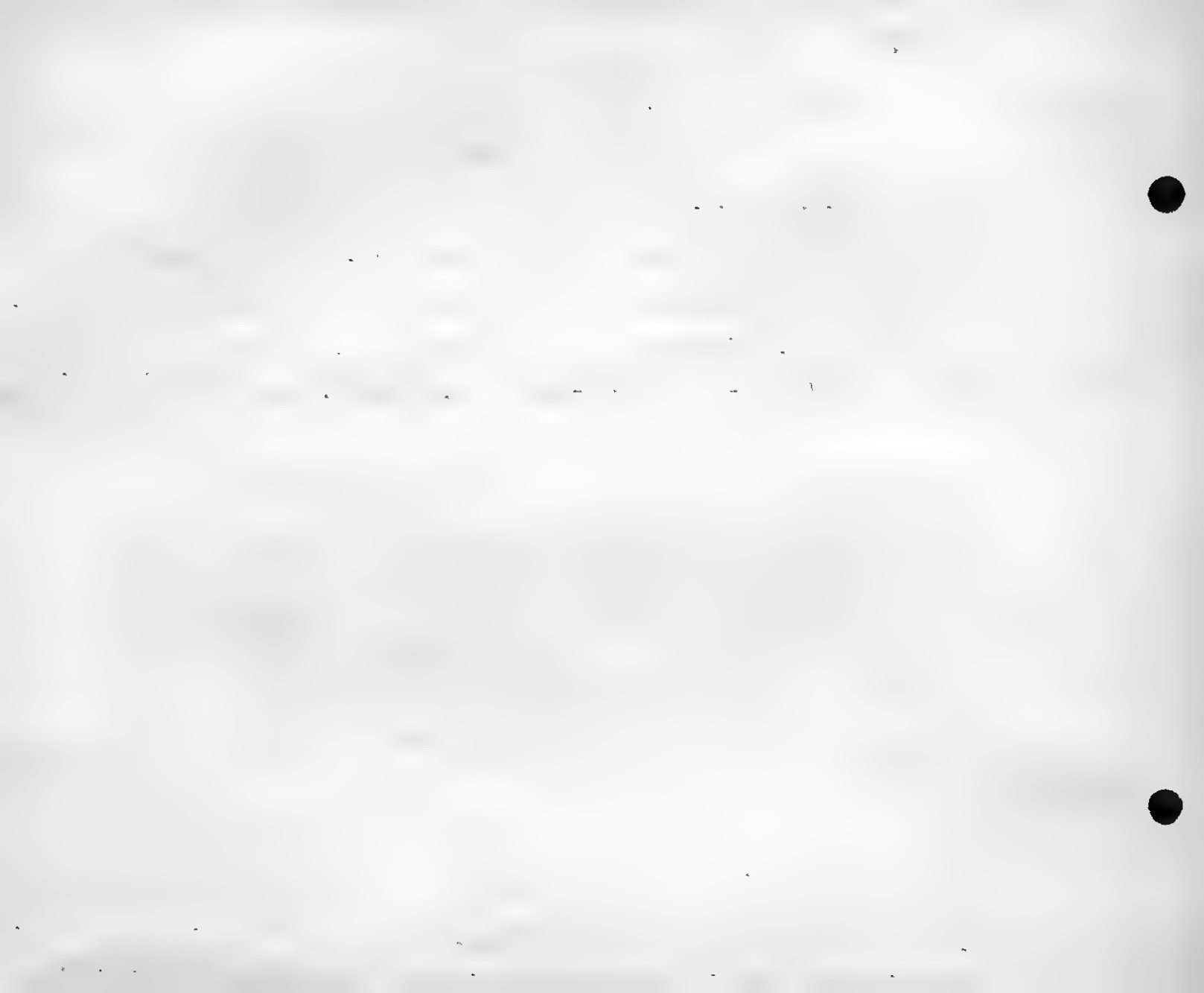
04266

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) William Gerald Wilkes | | | 2a. DATE OF DEATH
Month March Day 26 Year 1969 | | | 2b. HOUR
12:30 PM | |
| 3 SEX
male | | 4 RACE
white | | 5. DATE OF BIRTH
1-28-76 | | 6. AGE (In years last birthday)
93 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery Md. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington Sanitarium & Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired Pressman | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Maryland | | 13b. COUNTY
Prince Georges | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
6415 Knollbrook Drive | | 14. FATHER'S NAME
First Gerald Middle Wilkes Last Wilkes | | 15. MOTHER'S MAIDEN NAME
First Margaret Middle Allen Last Allen | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO
577-30-6712 | | 17. INFORMANT
Records - Washington Sanitarium & Hospital | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Hypertensive heart disease - A.V. Block & failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Dronabin | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
acute
2 day. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY
(At home, farm, street, factory, office building, etc.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 26 , 19 67 , to Mar 26 , 19 69 , that (II) (we) lost saw the deceased only on Mar 26 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (II) (we) (did) (did not) view the body after death | | | | | | | |
| 22b. SIGNATURE
Ernest A. Sarao | | | | 22c. DATE SIGNED
3/26/69 | | 22d. PHYSICIAN'S NAME (Type)
ERNEST A. SARAO M.D. | |
| 22e. ADDRESS
7006 New Hampshires Ave Takoma Park Md | | 23a. BURIAL CREMATION
Burial | | 23b. DATE
3/29/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Wash. Nat. Cem. | |
| 23d. LOCATION (City or Town)
Suitland, Md. | | 23e. RECORD BY REGISTRAR
APR 1 1969 | | 23f. REGISTRAR'S SIGNATURE
Willie J. ... | | | |
| 24. FUNERAL DIRECTOR
Halley's Funeral Home Inc. Maryland | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | | First
Walter | | | Middle
L. | | | Last
Wilkins | | | 2a. DATE OF DEATH
3 Month 31 Day 69 Year | | | 2b. HOUR
5:45 P.M. | | |
| 3 SEX
Male | | | 4 RACE
White | | | 5 DATE OF BIRTH
January 21, 1894 | | | 6 AGE (in years
lost birthday)
75 YRS. | | | 7 UNDER 1 YEAR
MONTHS | | | 8 UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
Washington, D.C. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Montgomery Md | | | | | | | | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Carriage Hill Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired).
Ret. Treasurer-Fairfax Dist. Co. | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before
admission) STATE
Maryland | | | 13b. COUNTY
Montgomery | | | 13c. CITY OR TOWN
Silver Spring | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
1607 South Springwood Dr. | | | | | |
| 14 FATHER'S NAME
First
John | | | Middle
L. | | | Last
Wilkins | | | 15 MOTHER'S MAIDEN NAME First
Catherine M. | | | Middle
Dieste | | | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown)
Yes | | | 16b. SOCIAL SECURITY NO
(If not give year or dates of service)
441-1917-1919 | | | 16c. 577-07-9812 | | | 17 INFORMANT (Daughter)
Mrs. Louise A. Emmell-1903 East West Hwy | | | Address
S.S., Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Pneumonia, chronic</u> | | | | | | | | | | | | 1 week | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Angiostenosis of coronary arteries</u> | | | | | | | | | | | | 2 weeks | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Extensive heart disease</u> | | | | | | | | | | | | 2 years | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Coronary atherosclerosis 10-30-68</u> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE, BUILDING ETC) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 1, 1966</u> , to <u>March 31, 1969</u> , that (I) (we) last
saw the deceased alive on <u>3-22-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Samuel T. Kimble</u> MD DEGREE | | | | | | | | | | | | ATTENDING
PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED
3-31-69 | | |
| 22d. PHYSICIAN'S
NAME (Type) <u>Samuel T. Kimble</u> | | | | | | | | | | | | 22e. ADDRESS
<u>9801 Georgia Ave, Silver Spring, Md.</u> | | | | | |
| 23a. BURIAL CREMATION,
REMOVAL (Specify) | | | 23b. DATE
April 3, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Montgomery Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> <u>8434 Georgia Avenue</u>
<u>Silver Spring, Md.</u> | | | | | | | | | | | | 25a. REC'D BY REG. STRAR
DATE <u>APR 7 1969</u> | | | 25b. REG. STRAR'S SIGNATURE
<u>J. Charles Judge</u> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---------|--|------------------|--|--|---------------------------------|--|--|--|--|
| 04276 | | 04268 | | | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2i. HOUR: P | | |
| Gene Austin Williams | | | | | | March 25 69 | | | 12:30 M | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Male | | White | | 29 July 1937 | | | 31 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Virginia | | | U.S.A. | | | | | | Montgomery Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bethesda | | | The Clinical Center, NIH | | | Reporter | | | Publishing Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Virginia | | | Warren | | | Front Royal | | YES | | 423 Duncan Avenue | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | | |
| Aylor G. Williams | | | Neville North | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | The Medical Record Address | | |
| no | | | 223-46-3915 | | | The Clinical Center, NIH, Bethesda, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest during surgery</u> | | | | | | | | | | 30 minutes | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Brain Tumor, Right Frontal, probable meningioma</u> | | | | | | | | | | years | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
<u>Hodgkin's Disease - clinically in remission</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 3/25/69 | | | Brain tumor | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | YES | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory)
OFFICE BUILDING, ETC. | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>11 March, 1969</u> , to <u>25 March, 1969</u> , that (X) (we) last saw the deceased alive on <u>25 March, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Robert E. Curran</u> | | | | | | 22c. DATE SIGNED
25 March 1969 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Robert E. Curran, M.D. | | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 3/28/69 | | | Willis Chapel Cemetery | | | Rappahannock Co. Virginia | | |
| 24. FUNERAL DIRECTOR
Robertshaw & Turner | | | | | | ADDRESS
Front Royal, Virginia | | | 25a. REC'D BY REGISTRAR
DATE APR 1 1969 | | |
| | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | |



04277

CERTIFICATE OF DEATH

04269

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR P | | |
| Norman Lansdale Williams | | | | | | March 4, 1969 | | | 4:45 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS. | |
| Male | | White | | June 6, 1894 | | 74 YRS | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Olney | | | Montgomery Gen. Hosp. | | | Farmer | | | Farming | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Montgomery | | Germantown | | | | Rt. 1, Box 110 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Joseph Williams | | | Sophronia Anderson | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| No | | | 215-32-2576 | | Mrs Hilda M. Williams, Germantown, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Advanced Arteriosclerotic Cardiovascular Disease 15 years
DUE TO, OR AS A CONSEQUENCE OF with Hypertension.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Terminal Pneumonitis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| None | | -- | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | -- | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)
No Injury | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1935, 19, to March 4, 1969, that (I) (we) lost saw the deceased alive on March 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M. McKendree Boyer, M. D. | | | | | | DEGREE
ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED
March 5, 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| M. McKendree Boyer, M. D. | | | | | | 9701 Church Street
Damascus, Maryland. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | March 7, 1969 | | Salem Meth. | | Cedar Grove, Md. | | | | | |
| 24. FUNERAL DIRECTOR
Olin L. Molesworth, Damascus, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 7 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

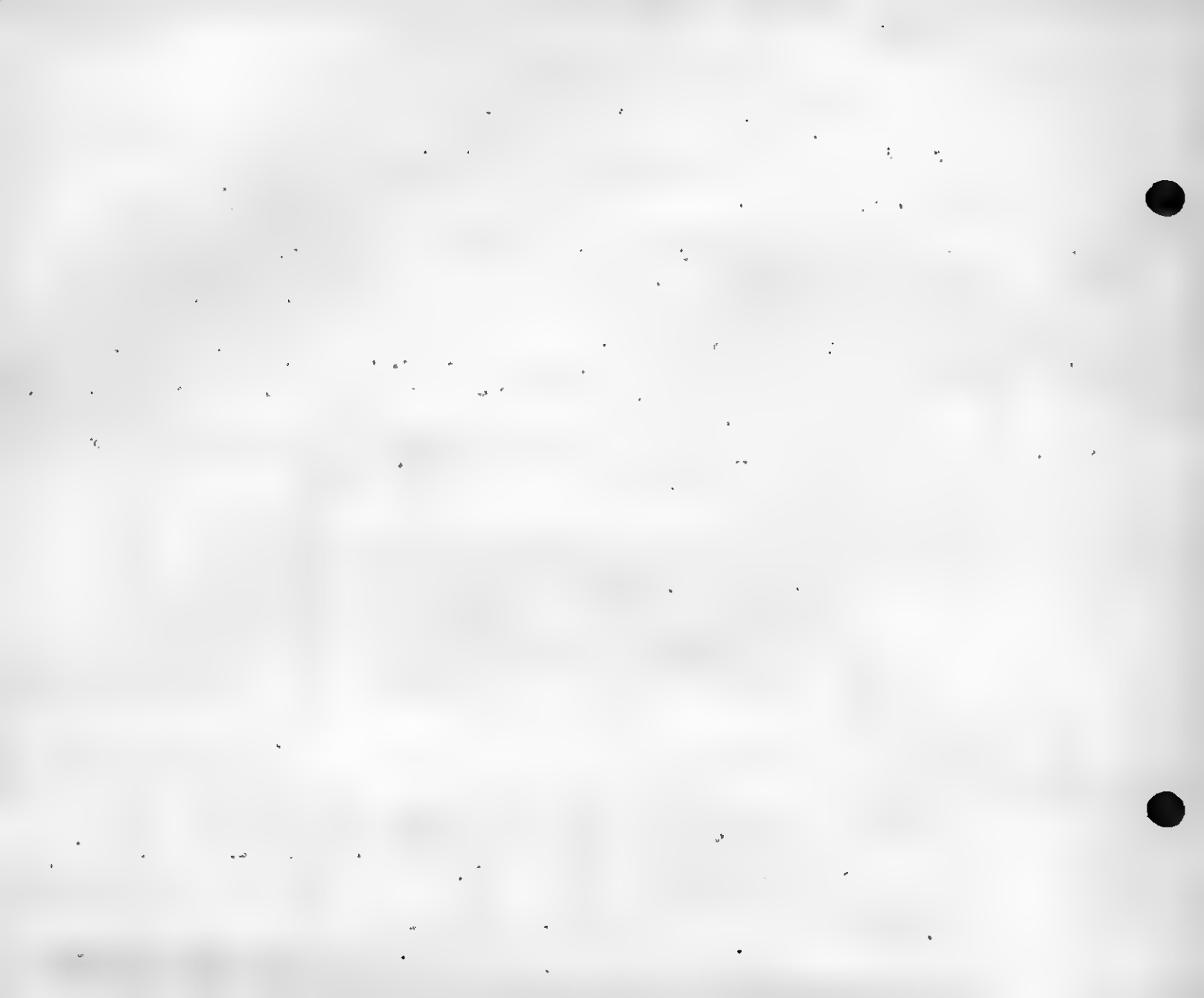
04278

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04270

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|---|---|-------------------|---|---|---|--------------------------------------|--|------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR P | | |
| Sibyl | | | Alexia | Williams | | March 21 1969 | | | 10:05 M | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| Female | | Negro | | 2 January 1956 | | 13 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Pennsylvania | | USA | | | | Montgomery Mo | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| Bethesda | | | The Clinical Center, NIH | | | Student | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Pennsylvania | | | | | Harrisburg | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 605 North 15th Street | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Glenn | | | E. | Williams, Jr. | | Elizabeth | | | R. | Russell | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT The Medical Record Address | | | | | |
| No | | | None | | | The Clinical Center, NIH, Bethesda, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Multiple cardiac arrests
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. 2500
(b) Diabetic ketoacidosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 hours
12 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Acute lymphocytic leukemia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Feb. 12, 1969, to March 21, 1969, that (A) (we) last
saw the deceased alive on March 21, 1969, and that in (our) (our) opinion death occurred on the date and hour and from the
causes stated above, (X) (we) (did) (view) the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert B. Livingston MD DEGREE | | | | | | ATTENDING
PHYS <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
22 March 1969 | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Robert B. Livingston, M.D. | | | | | | 22e. ADDRESS The Clinical Center, National
Institutes of Health, Bethesda, Maryland | | | | | |
| 23a. BURIAL CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 3-25-1969 | | Wm Howard Boy Cemetery | | Hickory, Pa. | | | | | |
| 24. FUNERAL DIRECTOR
Melvin Harper - 1416 Cumberland St | | | | | | 25a. REC'D BY REGISTRAR
DATE APR 7 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VA 5 14
45M - 1-66

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 04279 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04271 | |
| 1 DECEASED NAME (Type or print) First Middle Last
Mildred E. Wilson | | | | | | 2a DATE OF DEATH Month Day Year
3-26-69 | |
| 3 SEX
Female | | 4 RACE
white | | 5. DATE OF BIRTH
12-21-27 | | 6 AGE (In years last birthday)
41 YRS. | |
| 7a BIRTHPLACE (State or foreign country)
Md. | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | |
| 10 CITY OR TOWN OF DEATH
Bethesda | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
Suburban. | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Cleric | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived at admission) STATE
Md. | | 13b COUNTY
Prince George's | | 13c CITY OR TOWN
Hyattsville | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e STREET AND NUMBER
6806 Highview Terrace | | 14 FATHER'S NAME First Middle Last
JOSH GROVES | | 15 MOTHER'S M A D E N NAME First Middle Last
Ella Bleden | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b SOCIAL SECURITY NO
57234-7515 | | 17 INFORMANT
ANDREW K. WILSON | | Address
SAME AS #13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cirrhosis, liver, Laennec's, advanced
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 yrs. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
None | | | | | | | |
| 19a. DATE OF OPERATION
NA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
NA | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NA | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY
HOUR A.M. Month Day Year
PM 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No | | City or Town County State | |
| 22a I certify that (I) (this hospital) attended the deceased from 11:31, 1969, to 3:20, 1969, that (I) (we) saw the deceased alive on 3/26/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b SIGNATURE
EXAR A LEVIN | | | | 22c. DATE SIGNED
3/27/69 | | 22d PHYSICIAN'S NAME (Type)
EXAR A LEVIN | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE
3-29-1969 | | 23c NAME OF CEMETERY OR CREMATORY
ROCK CREEK CEM | | 23d LOCATION (City or Town) (County) (State)
WASHINGTON, D.C. | |
| 24 FUNERAL DIRECTOR
W.W. CHAMBERS CO RIVERDALE, MD | | | | 25a REC'D BY REGISTRAR
DA APR 1 1969 | | 25b REGISTRAR'S SIGNATURE
John A. Judge | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 1-18 2a Film 411 MARYLAND STATE DEPARTMENT OF HEALTH
4-3-69 was DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04280

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04272

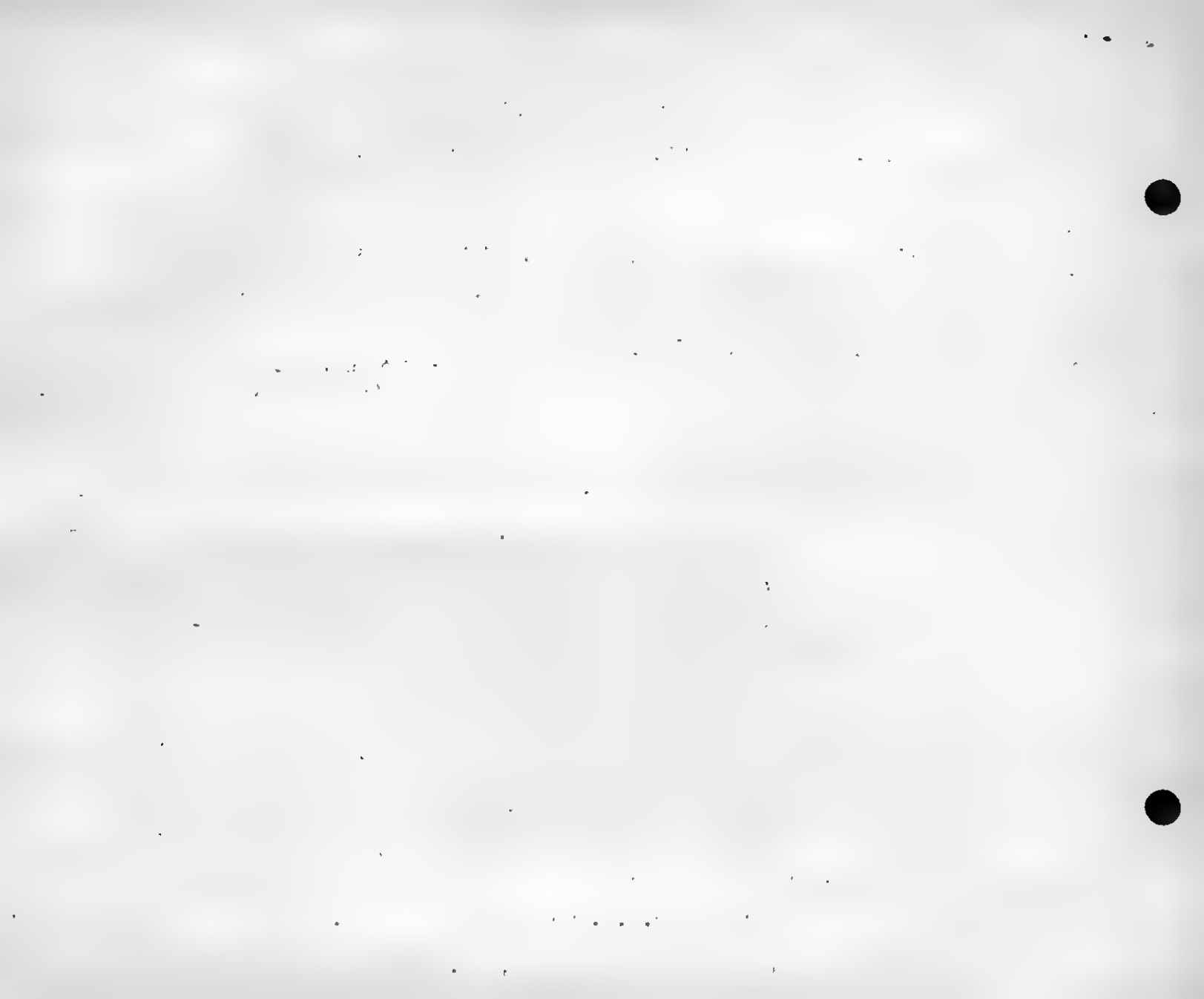
| | | | | | | | | | |
|--|-------------------------|---|---|--|---|---|--|---|--|
| 1. DECEASED NAME
(Type or Print) JAMES Henry WISER | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 23 Year 1969 | | | 2b. HOUR 3:06 | | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
7-22-97 | 6. AGE (In years last birthday)
71 YRS | IF UNDER 1 YEAR
MONTHS 11 DAYS 22 | IF UNDER 24 HRS
HOURS 3 MIN 06 | 2c. DATE PRONOUNCED DEAD
Month 3 Day 23 Year 1969 | | | |
| 7a. BIRTHPLACE (State or foreign country)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Montgomery | | | |
| 10. CITY OR TOWN OF DEATH
T. Komark | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Wash. San. & Hosp. | | 12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Md. | | 13b. COUNTY
Mont. | | 13c. CITY OR TOWN
T.P. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
6806 Laurel St. | |
| 14. FATHER'S NAME
First Harry Middle Bartley Last Nash | | | 15. MOTHER'S MAIDEN NAME
First Mary Middle Nash Last Nash | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16b. SOCIAL SECURITY NO
--? | | 17. INFORMANT
Peters Funeral Home Gettysburg, Penn. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per one far (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute rt. coronar. thrombosis
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office bldg., etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Peap | | EXAMINER'S NAME (Type)
BELDEN R. PEAP M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASS STANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-26-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Fairview Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Mercersburg, Penn. | | 22b. DATE SIGNED
3/23/1969 | |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey Inc. | | | | ADDRESS
8434 Ga. Ave. Spring, Md. | | 25a. REC'D BY REGISTRAR
MAR 28 1969 | | 25b. REGISTRAR'S SIGNATURE
W. E. Pumphrey | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|---|---|--|---|---|--------|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 04281 CERTIFICATE OF DEATH 04273 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
A M | | |
| Ronald Joseph Wisniewski | | | | | | March 8 1969 | | | 3:45 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | |
| Male | | White | | 5 March 1962 | | 7 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Virginia | | USA | | | | Montgomery Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bethesda | | | The Clinical Center, NIH | | | Student | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Virginia | | | Fairfax | | Springfield | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6711 Jerome Street | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Louis R. Wisniewski | | | | | | Anna Sitko | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT The Medical Record Address | | | | | |
| No | | | None | | | The Clinical Center, NIH, Bethesda, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
<u>746.4</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Operative repair-atrial septal defect</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Congenital heart disease</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>
<u>4 hours</u>
<u>7 years</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Cerebral edema</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | |
| 3/7/69 | | Atrial Septal Defect | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | County | State | |
| | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>2 March</u> , 19 <u>69</u> , to <u>8 March</u> , 19 <u>69</u> , that (X) (we) last saw the deceased alive on <u>8 March</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Edward Jacobs, Jr., M.D.</u> | | | | | | 22c. DATE SIGNED
March 8 1969 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Edward Jacobs, Jr., M.D. | | | | | | 22e. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Maryland | | | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) | | |
| Burial | | 3/11/1969 | | M.O.C. Cemetery | | Mt. Carmel | | | Pennsylvania | | |
| 24. FUNERAL DIRECTOR
1331 Rockville Pike
Tyson Wheeler Funeral Home Rockville, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 12 1969 | | 25b. REGISTRAR'S SIGNATURE | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04282

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04274

| | | | | | | | | |
|--|--------------------|--|--|---|---|---|---|--|
| 1 DECEASED-NAME
(Type or Print) NORMAN H. WOLFE | | | 2a. DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> Month 3 Day 21 Year 1969 | | | 2b. HOUR 1:45 M P | | |
| 3 SEX M | 4 RACE Cauc | 5 DATE OF BIRTH 7-4-1887 | 6 AGE (In years last birthday) 87 YRS | IF ENDER 1 YEAR MONTHS 0 DAYS 0 | IF UNDER 24 HRS HOURS 0 MIN 0 | 2c. DATE PRONOUNCED DEAD Month 3 Day 21 Year 1969 | | |
| 7a BIRTH-PLACE (State or foreign country) md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Montgomery Md | | |
| 10 CITY OR TOWN OF DEATH Cherry Chase | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9015 Jones Mill Rd | | 12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Farming | | |
| 13a USUAL RESIDENCE (Where deceased lived, if instituton Residence before admission) STATE md | | 13b. COUNTY Montgomery | | 13c CITY OR TOWN Cherry Chase | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 9015 Jones Mill Rd. |
| 14 FATHER'S NAME First Jesse Middle Wolfe Last Wolfe | | | 15 MOTHER'S MAIDEN NAME First Laura Middle Hyatt Last Hyatt | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT Mary H. Kirtland ADDRESS (SAME) | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound in
955X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Heart with Exsanguination
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Depression - Senility | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b TIME OF INJURY Month, Day, Year 11:00 AM 3-21 1969 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased depressed, shot self with shotgun | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory office building, etc.) Rear of home | | 21f LOCATION Street or R.F.D. No 9015 Jones Mill Rd City or Town Cherry Chase County Montg. State Md. | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE Belden R. Deaf | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED MARCH 21, 1969 | | |
| EXAMINER'S NAME (Type) BELDEN R. DEAF, MD. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 23b DATE 3/24/69 | | 23c NAME OF CEMETERY OR CREMATORY Monacacy | | 23d. LOCATION (City or Town) (County) (State) Beallsville Montg. Md. | |
| 24 FUNERAL DIRECTOR Constance C. Hilton Barneville Tpd. | | | ADDRESS | | 25a REC'D BY REGISTRAR MAR 28 1969 | | 25b REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 04283 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04275 | |
|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1 DECEASED NAME
(Type or print) | | First | | Middle | | Last | |
| JOANN GATES WOODSON | | | | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 2a. DATE OF DEATH | |
| FEMALE | | CAUC | | 14 DEC. 1920 | | MARCH 04 1969 | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 6 AGE (in years last birthday) | |
| WASH. | | USA | | | | 48 YRS. | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| BETHESDA | | NAVAL HOSPITAL, BETHESDA | | HOUSEWIFE | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | |
| VIRGINIA | | FAIRFAX | | LORTON | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME | | First | | Middle | | Last | |
| ROSS E. WILSON | | | | | | | |
| 15 MOTHER'S MAIDEN NAME | | First | | Middle | | Last | |
| MAURINE GATES | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | Address | |
| NO | | UNKNOWN | | WALTER B. WOODSON | | 10608 BELMONT BLVD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Melanoma with generalized metastases | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| | | HOUR A.M. Month Day Year
P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (A) (this hospital) attended the deceased from 6 FEB 1969, to 4 MARCH 1969, that (A) (the) last saw the deceased alive on 4 MARCH 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | |
| E. DIAMOND, M.D. | | 5 MARCH 1969 | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | |
| 22e. ADDRESS | | 22f. ADDRESS | | | | | |
| Naval Hospital, Bethesda, Maryland | | | | | | | |
| 23a. BURIAL CREMATION | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| CREMATION | | 3/6/1969 | | Lee's Crematory | | Washington, D C | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| DEMAINE FUNERAL HOME | | ALEXANDRIA, VA. | | DATE MAR 10 1969 | | Charles Judge | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | |
|---|---------------------|---|--|--|---|--|--|
| 04284 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 04276 | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or Print) <i>Myrtle Esther Wright</i> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>3</i> Day <i>2</i> Year <i>1969</i> | | | 2b. HOUR <i>8:45</i> AM | |
| 3. SEX <i>Fe</i> | 4. RACE <i>Cauc</i> | 5. DATE OF BIRTH <i>July 21, 1878</i> | 6. AGE (In years birthday) <i>90</i> YRS. | IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> | IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i> | 2c. DATE PRONOUNCED DEAD Month <i>3</i> Day <i>2</i> Year <i>1969</i> | |
| 7a. BIRTHPLACE (State or foreign country) <i>Ohio</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Montgomery</i> Md. | |
| 10. CITY OR TOWN OF DEATH <i>Silver Spring</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>2903 Newton St.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Montgomery</i> | | 13c. CITY OR TOWN <i>Silver Spring</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First <i>Brinton B. Hoopes</i> | | 15. MOTHER'S MAIDEN NAME First <i>Elizabeth Moore</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>177 22 2710</i> | |
| 17. INFORMANT <i>A Vera Weston</i> | | 17. ADDRESS <i>2903 Newton St. Silver Spring, Md.</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4123 Acute Coronary Insufficiency</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (b) <i>Arteriosclerotic Heart Disease</i> | | (c) <i></i> | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i></i> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year <i>19</i> HOURS A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>Belden R. Reap</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED <i>MARCH 3, 1969</i> | |
| EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, City, Town, or County) <i>Conover</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>Mar 4, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Lansdale, Penn.</i> | |
| 24. FUNERAL DIRECTOR <i>Paul J. Smith Warner E. Pumphrey Inc.</i> | | 24. ADDRESS <i>8434 Ga. Ave. Silver Spring, Md.</i> | | 25a. REC'D BY REGISTRAR DATE <i>MAR 4 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>J. J. Judge</i> | |

1930

DATE
1930

Handwritten notes and entries, mostly illegible due to fading and bleed-through. Some legible fragments include:

- Top left: "1930", "1930", "1930"
- Top center: "1930", "1930", "1930"
- Top right: "1930", "1930", "1930"
- Middle left: "1930", "1930", "1930"
- Middle center: "1930", "1930", "1930"
- Middle right: "1930", "1930", "1930"
- Bottom left: "1930", "1930", "1930"
- Bottom center: "1930", "1930", "1930"
- Bottom right: "1930", "1930", "1930"

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|--|--|
| 04285 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 04277 | |
| Item 5 Film 410 3/13/69 wk | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME
(Type or print) <i>Grace A Zemke</i> | | | 2a. DATE OF DEATH
Month <i>March</i> Day <i>4</i> Year <i>1969</i> | | 2b. HOUR
<i>11:15</i> M |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
<i>3/21/1916</i> 1894 | | 6. AGE (In years last birthday)
<i>74</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
<i>CANADA</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 9. COUNTY OF DEATH
<i>Montgomery</i> Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Suburban</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Retired</i> | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md</i> | 13b. COUNTY
<i>Mont</i> | 13c. CITY OR TOWN
<i>Rockville</i> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
<i>199 Collins Ave -</i> | |
| 14. FATHER'S NAME
First <i>ROBERT</i> Middle <i>Laidlaw</i> | | 15. MOTHER'S MAIDEN NAME
First <i>CLARA</i> Middle <i>Armington</i> Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>382-20-7210</i> | 17. INFORMANT
<i>Robert W. Zemke</i> <i>7029 Stearns St. Long Beach, Cal.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
<i>1539</i> IMMEDIATE CAUSE (a) <i>Carcinoma of Bowel, metastatic to liver</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>to liver</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 weeks</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/17/69</i> to <i>THE PRESENT</i> that (I) (we) last saw the deceased alive on <i>MARCH 3 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Edward W. Youngblood</i> | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED
<i>March 4, 1969</i> | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>EDWARD W. YOUNGBLOOD</i> | | 22e. ADDRESS
<i>WASHINGTON CLINIC, WASH, D.C.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Cremation</i> | 23b. DATE
<i>3/4/69</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Prince George Co., Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 11 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Richard J. Judge</i> | |

Scholarship

1998